

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Please sign and completely fill in by the funeral director. Page 4 may be resigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be returned to the funeral director. Then please file it with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal of the body. If Item 21 is marked or if either injury or item 18a shows any injury, or if either traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
LOSAYA					AKYUZ	November	6	1986	0825	M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		Caucasian		July 29, 1931		55 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Armenia		Turkey						MONTGOMERY County MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION 12b. KIND OF BUSINESS OR INDUSTRY		12c. CITY OR TOWN		13. STREET ADDRESS / ZIP CODE		
BETHESDA		SUBURBAN HOSPITAL		Homemaker		Rockville		11923 Parklawn Drive #101		
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20852		
Maryland		Montgomery								
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		16. SOCIAL SECURITY NO.		not available		
Alexan			Hasar	Mariam		217-98-3976				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no				Istepan Akyuz, same as #13				hours		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										
Probable Peritonitis and Sepsis										
DUE TO, OR AS A CONSEQUENCE OF (b) Abdominal Carcinomatosis months										
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic ovarian Cancer months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 17, 1986, to 17, 1986, that (I) (the hospital) saw the deceased alive on 11/6, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (If (I) (the hospital) did not) view the body after death.										
22b. SIGNATURE <i>Stephen J. Newman</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/6/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman, M.D.		22e. ADDRESS 11500 Old Georgetown Road Rockville, Maryland 20852								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Nov. 7, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN Silver Spring, Maryland				
Burial										
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814 PA		25a. DATE REC'D. BY REGISTRAR NOV 10 1986		25b. REGISTRAR'S SIGNATURE <i>Jeanne Sanderson-Kendall</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy, pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called and/or see

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
VIOLA				M.	ALLEN SWORTH	November 2, 1986				5:53 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS MIN.		
Female	Caucasian	MONTH DAY YEAR Sept. 22, 1903			83						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Georgia	U.S.A.				Montgomery						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Wheaton	University Nursing Home					Real Estate Agent Real Estate					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland	Montgomery	Silver Spring	YES <input type="checkbox"/> NO <input type="checkbox"/>			10000 Brunswick Ave. 20902					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Thomas			Flint	FIRST MIDDLE LAST Mary McGrath							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO	579-03-8030			daughter Barbara A. Candland			ADDITIONAL POTOMAC, Md. 20854 3 hours.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cerebral vascular episode</u>											
DUE TO, OR AS A CONSEQUENCE OF { (b) <u>cerebral vascular occlusion</u> 18 months											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic vascular disease</u> 20 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Previous cerebral vascular occlusion 1982, since cachexia</u>											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19, 1982</u> to <u>Nov. 2, 1986</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 19, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Arthur S. Bresler, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											22c. DATE SIGNED <u>10-2-86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Arthur Bresler, M.D.</u>											22e. ADDRESS <u>10881 Lockwood Drive, Silver Spring, Md. 20901</u>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Nov. 4, 1986</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>George Washington Cemetery Adelphi Prince Georges Md.</u>			23d. LOCATION CITY OR TOWN <u>Adelphi</u> COUNTY <u>Prince Georges</u> STATE <u>Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins, Jr.</u>		ADDRESS <u>500 University Blvd. West, Silver Spring, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 6 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Dawson-Bardell</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please return the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. If item 21 is marked or if there is any injury, or other significant condition contributing to death, the medical examiner should be notified.

IMPORTANT: If item 21 is marked or item 18 contains any injury, or other significant condition contributing to death, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR		2b. HOUR						
Leroy Montgomery Allison Sr					Nov 21 1986		1:05pm						
3. SEX <i>Male</i>		4. RACE <i>White</i>			5. DATE OF BIRTH MONTH DAY YEAR November 28, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i>						
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Rockville Nursing Home</i>			12a. USUAL OCCUPATION <i>Structural Supervisor</i>		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov. Construction						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Damascus</i>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>10125 Johns Drive/ 20872</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Horatio C. Allison</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hester O'Neal</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>N/A 577-10-8105</i>		17. INFORMANT (Wife) <i>Bessie Z. Allison</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery disease</i> (c) <i>Arteriosclerosis</i>										DUE TO, OR AS A CONSEQUENCE OF years <i>years</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										11			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>oak st</i>		CITY OR TOWN <i>date</i>						
22a. I certify that (I) <i>this hospital</i> attended the deceased from saw the deceased alive on <i>11/21/86</i> at <i>oak st</i> , 19 <i>10</i> , and that in my <i>last</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> did not view the body after death.													
22b. SIGNATURE <i>John G. Ward</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22d. DATE SIGNED <i>11/21/86</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John G. Ward</i>		22f. ADDRESS <i>6116 Reinhardt Bethesda 20817</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE 1986 <i>November 23</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN <i>Alexandria</i>		COUNTRY STATE <i>Virginia</i>					
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Home P.A. 7557 Wisconsin Ave, Bethesda, MD</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 24 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Deardon-Reader</i>									

CHICAGO
ILLINOIS
U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please staple carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

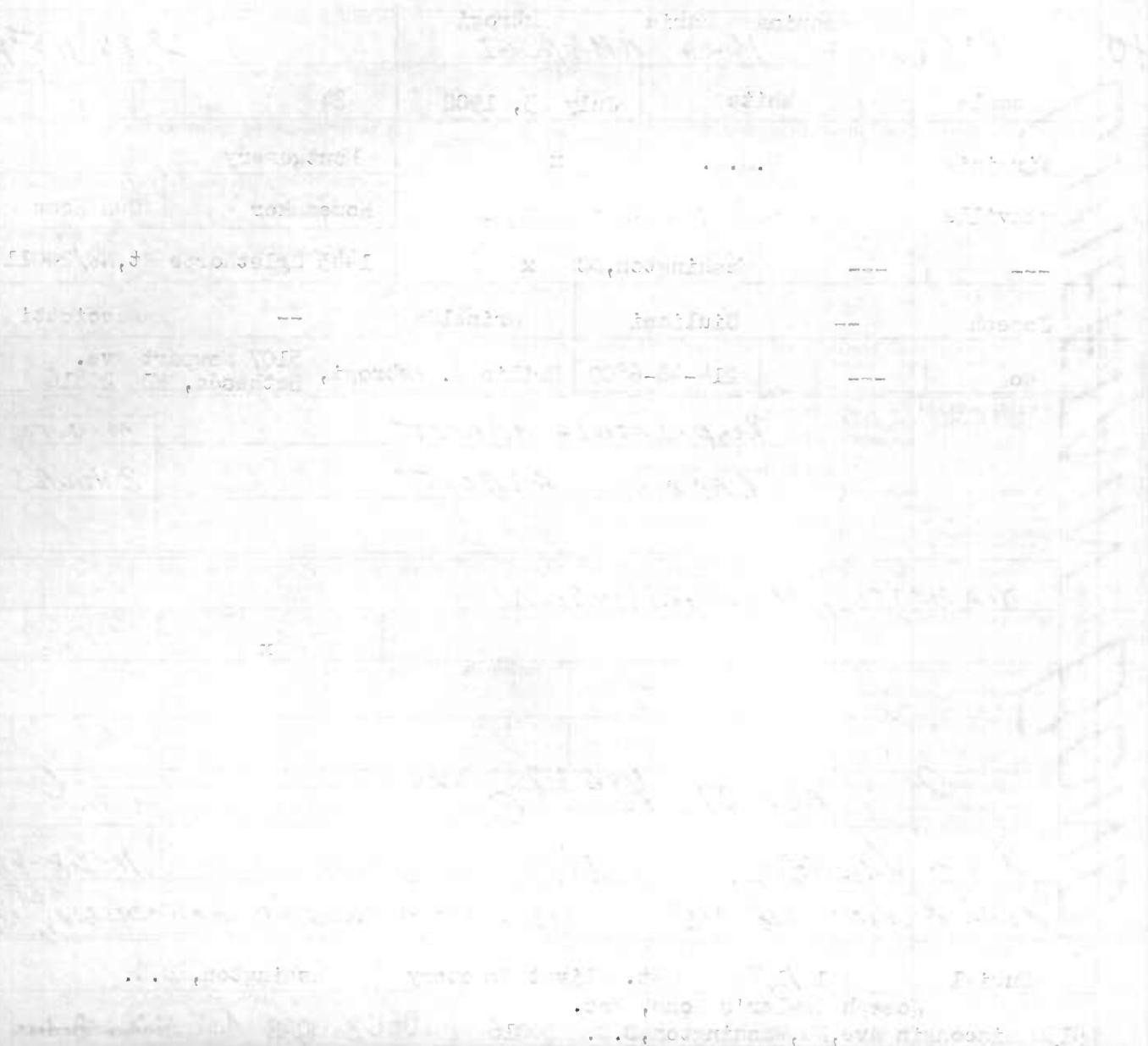
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) PASQUINA MARIA AMBROGI			2a. DATE OF DEATH MONTH DAY YEAR 11 27 86		2b. HOUR 1157PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 3, 1902		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SILVER GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE ---		13b. COUNTY ---		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Joseph		MIDDLE ---		LAST Giuliani		15. MOTHER'S MAIDEN NAME FIRST Griselda	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-48-6809		17. INFORMANT Emilio D. Ambrogi,		ADDRESS 5107 Newport Ave. Bethesda, MD 20816	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES							
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a DIABETES, HYPERTENSION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from NOV 27 1986 , to NOV 27 1986 , that (I) (we) last saw the deceased alive on NOV 27 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alan R. Vinitsky		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-28-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. VINITSKY MD.		22e. ADDRESS 12116 Daane Stoney Rd. Gaithersburg, Md. 20878					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/1/86		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Washington, D.C.	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				25a. DATE REC'D. BY REGISTRAR DEC 3 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016							

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16 hours within 24 hours after death. Page 4 may be

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE
REGISTRAR

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "HOLDING" IN PENCIL IN ITEM 1B. SIGNATURES ON PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS FORM. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR RELEASAL.

1- USED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR
<i>Robert Barrett Alsop</i>				<i>Alsop</i>	<i>Nov. 10</i>	<i>19</i>	<i>86</i>	<i>Nov. 10</i>	<i>19</i>	<i>86</i>	<i>X</i>	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) EAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. UNDER 24 HRS. HOURS MIN.							
<i>m</i>	<i>caucasian</i>	<i>April 26 1917 69</i>	<i>YRS.</i>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Washington, D. C.</i>		<i>U.S.A.</i>			<i>X</i>			<i>Montgomery</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Silver Spring</i>		<i>10205 Douglas Ave</i>			<i>Laborer</i>			<i>20902</i>				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
<i>MD</i>		<i>Montgomery</i>		<i>Silver Spring</i>		<i>X</i>		<i>10205 Douglas Ave</i>				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
<i>Carl</i>		<i>E.</i>	<i>Alsop</i>	<i>Annie</i>			<i>Barrett</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>No</i>		<i>579-14-6108</i>		<i>friend</i>		<i>Robert F. Costello, III Silver Spring, Md.</i>		<i>20910</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Santa Monica Cardiac Div.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>												
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>do</i>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, <i>John S. Rogers</i> , M.D., and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>John S. Rogers, M.D.</i>			DATE SIGNED <i>Nov 10 1986</i>							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 1919 Seminary Road Silver Spring, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Nov. 14, 1986</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Brentwood</i>		COUNTY	STATE	
BP												
DHMH - 17 (VR A15 ME (5)) 15M 7/76												
24. FUNERAL DIRECTOR NAME		Francis J. Collins, Jr.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
								<i>NOV 14 1986</i>		<i>J. S. Rogers</i>		
500 University Blvd., W. Silver Spring, Md.												

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE MAILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. <i>8 0 5 2 0 6</i>			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Heinrich			MIDDLE			LAST Amrein			2a. DATE KNOWN OF ESTI- DEATH MATED	2b. MONTH DAY YEAR		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1913			6. AGE (IN YEARS LAST BIRTHDAY) 72 yrs.			IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	2d. MONTH DAY YEAR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			2d HOUR <i>7:15 A.M.</i>			
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7914 Glenbrook Ridge Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Groundskeeper			12b. KIND OF BUSINESS OR INDUSTRY Self-employed						
13a. STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7914 Glenbrook Road 20814			
14. FATHER'S NAME Christof			MIDDLE Amrein			15. MOTHER'S MAIDEN NAME Rozalia			16. SOCIAL SECURITY NO. 220-32-6365			17. INFORMANT Kensington, Md. 20895 Maria A. Perkins(daughter) 4905 Cushing Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> INDEF DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>ACUTE</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETES</u> <u>MORTITUS</u> <u>ETHANOLISM</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR A.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>DIED IN BED</u>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>HOME</u>			21f. LOCATION STREET <u>7914 Glenbrook Rd</u> CITY OR TOWN <u>Bethesda</u> COUNTY <u>Montgomery</u> STATE									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion									
ACTUAL SIGNATURE <i>Francis C. Mayle</i>			TITLE (SPECIFY) M.D. <u>DET</u>			MEDICAL EXAMINER			DATE SIGNED <i>11/18/86</i>						
EXAMINER'S NAME (TYPE OR PRINT) <i>Francis C. Mayle</i>			ADDRESS <i>8200 Wisconsin Ave Bethesda</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/20/86			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN Silver Spring, Maryland						
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR <i>NOV 24 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon</i>						
DMMH - 17 (VR A15 ME (5))															

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TO HOSPITAL OR ATTENDING PHYSICIAN. The
attending physician by the hospital or attending physician.

• resulted within 24 hours after death. Photo 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial/trust permit. Then please receive carbon copies with the State Dept. of Health and Mental Hygiene prior to burial or removal.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 3 2 3 8 4

REG NO

DECEASED NAME (TYPE OR PRINT)			FIRST <i>Thelma Carman</i>	MIDDLE <i>Anderson</i>	LAST	2d. DATE OF DEATH MONTH DAY YEAR <i>11/25/86</i>	MONTH DAY YEAR	2b. HOUR 1 P.M.			
3. SEX <i>Female</i>	4. RACE <i>black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 8 12</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>74 yrs</i>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Jamaica</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>								
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>8100 Flower Ave</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>						
13a. STATE <i>MD</i>	13b. COUNTY <i>Dade</i>	13c. CITY OR TOWN <i>Miami</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>8230 NE First Place 33138</i>					
14. FATHER'S NAME FIRST <i>Thomas</i>	MIDDLE <i>Byron</i>	LAST <i>Howard</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Helen</i>			MIDDLE <i>Louise</i>	LAST <i>Rainford</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	16b. SOCIAL SECURITY NO. <i>1764246398</i>	17. INFORMANT <i>Marjorie Bumbrey</i>	ADDRESS <i>510 R St. NW Washington DC 20011</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Stomach (Metastatic)</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 mos.</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Dehydration</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Malnutrition (Inability to Eat)</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 3</i> , 19 <i>86</i> , to <i>Nov. 25</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>Nov. 3</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED <i>Nov. 25, 1986</i>
22b. SIGNATURE <i>Samuel L. Deshay, M.D.</i>	DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SAMUEL L. DESHAY, M.D.</i>	22e. ADDRESS <i>1610 Carroll Ave. TAKOMA PARK, MD</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIES) <i>BURIAL</i>	23b. DATE <i>Nov. 29, 1986</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Southern Memorial Park</i>	23d. LOCATION CITY OR TOWN <i>Miami</i>	23e. COUNTY <i>Florida</i>							
24. FUNERAL DIRECTOR NAME <i>Takoma Funeral Home & Mortuary</i>	25a. ADDRESS <i>2571 Gamble St. NW DC</i>	25b. DATE REC'D. BY REGISTRAR <i>NOV 29 1986</i>	25b. REGISTRAR'S SIGNATURE <i>John Davis, Jr.</i>								

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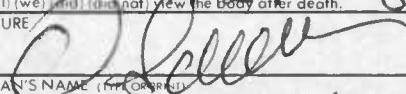


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal, it should be detached for use as the burial/transit permit.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32385					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST Nevart			MIDDLE		LAST Andre			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
3. SEX Female		4. RACE White			5. DATE OF BIRTH MONTH Feb. DAY 22 YEAR 1898					6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	MD.				
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9816 Woodford Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker					12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9816 Woodford Rd. 20854							
14. FATHER'S NAME FIRST Krikor		MIDDLE Der		LAST Krikorian		15. MOTHER'S MAIDEN NAME FIRST Haiiganoush		MIDDLE		LAST Vartanian					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 088-28-8110		17. INFORMANT Elizabeth Grigorian Same as item # 13		ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 27, 1971 to 11.27.1986 , that (I) (we) last saw the deceased on Feb. 27, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) and (I) (we) did not view the body after death.															
22b. SIGNATURE / 										DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES SAHAKIAN		22e. ADDRESS 5632 Annapolis Rd., Lancaster, PA		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11.27.86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/1/86		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Grove Cemetery		23d. LOCATION CITY OR TOWN Flushing, NY		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 W1 Ave. NW Wash., DC 20016										LAST DATE FACILITY REGISTERED FOR USE DEC 09 1986					

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified on death)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										863238				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
KATHERINE			T.	ARAVANIS			NOV. 9, 1986						10:00 A.M.	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
FEMALE			CAUCASION		MARCH. 19, 1916		70 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
NEW YORK			U.S.A.				MONTGOMERY CO.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
SILVER SPRING			2400 DEXTER AVE.		REAL ESTATE		PHANTEL H. HAGNER							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2400 DEXTER AVE. 20901						
14. FATHER'S NAME FIRST			MIDDLE	LAST		15. MOTHER'S MAIDEN NAME DIMETRA			MIDDLE	LAST			LOGOTHETIS	
GEORGE			THANOS			16b. SOCIAL SECURITY NO. 579-40-2635			17. INFORMANT SON	ADDRESS SILVER SPRING DR. 20901				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE PANCREAS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to, or as a consequence of														
(c) Due to, or as a consequence of														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (the hospital) attended the deceased from June 19, 1984, to November 9, 1986, that (we) lost saw the deceased alive on November 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE John J. Tauber										DEGREE MD	ATTENDING PHYSICIAN	<input type="checkbox"/> MEDICAL DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22c. DATE SIGNED 11-9-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Tauber			22e. ADDRESS 8218 WISCONSIN AVE Bethesda											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE NOV. 11, 1986		23c. NAME OF CEMETERY OR CREMATORIAL PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN ROCKVILLE		COUNTY	STATE MONT. MD.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS JR. SILVER SPRING, MD. 20901			25a. DATE REC'D. BY REGISTRAR NOV 14 1986							25b. REGISTRAR'S SIGNATURE John J. Collins Jr.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or hemmed, do not cut or damage the paper.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 2 5 8

1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE OF DEATH MONTH DAY YEAR	
ATHENA		—	—	ARGYROPoulos		12 26 86	2b. HOUR 5PM
3. SEX FEMALE		4. RACE CAUCASION		5. DATE OF BIRTH MONTH Jan. DAY 2, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Nicholas		MIDDLE	—	LAST Lagos		15. MOTHER'S MAIDEN NAME FIRST Florence	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Chris Argyropoulos, Washington, DC 20015		ADDRESS 7007 Wyndale St. NW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		(b) Heart Failure		DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET		CITY OR TOWN	
22a. SIGNATURE Leonard A. Wisneski, MD		22b. DEGREE		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leonard A. Wisneski, MD		22e. ADDRESS 6410 Rockledge Dr. #308		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/1/86	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		23c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery		23d. LOCATION CITY OR TOWN Washington, D.C.		25a. DATE REC'D. BY REGISTRAR DEC 03 1986	
25b. REGISTRAR'S SIGNATURE Julia David - L. de la		25c. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25d. DATE REC'D. BY REGISTRAR DEC 03 1986		25e. REGISTRAR'S SIGNATURE Julia David - L. de la	

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025462 DEC 1986

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN ITEM 1B, GIVE PAGES 1 & 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3 RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 6 3 2 3 8 0

1- FOR STATE REGISTRAR		LAST NAME ARTIE WALTER ASHBY										REG. NO.		
1. DECEDENT'S NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 25 01		6. AGE (IN YEARS) LAST BIRTHDAY 85 yrs.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		11 21 1986		6:28 AM
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		11 21 1986		6:28 AM
10. CITY OR TOWN OF DEATH SILVER SPRINGS		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Priv. Guard		12b. KIND OF BUSINESS OR INDUSTRY Security								
13. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8403 Longfellow Street		20784				
14. FATHER'S NAME FIRST Andrew		MIDDLE Jackson		LAST Ashby		15. MOTHER'S MAIDEN NAME FIRST Allie		MIDDLE R.		LAST Pruitt				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. — — —		17. INFORMANT Edna L. Alsop		18. CAUSE OF DEATH (Enter only one cause per line for part (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DUE TO, OR AS A CONSEQUENCE OF Fracture L. Hip (b) DUE TO, OR AS A CONSEQUENCE OF (c)		ADDRESS Same as 13e		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>														
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 11/13/86		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 13 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell in N.H.										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N.H.		21f. LOCATION STREET Arbutus Ave. S. 1. 1/2 pg. Mont. Md.										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> ., Inspection <input checked="" type="checkbox"/> ., Inquiry <input type="checkbox"/> ., and in my opinion death resulted from: Natural causes <input type="checkbox"/> ., Accident <input checked="" type="checkbox"/> ., Suicide <input type="checkbox"/> ., Homicide <input type="checkbox"/> ., Undetermined manner <input type="checkbox"/> .														
22b. ACTUAL SIGNATURE <i>John S. Rogers</i> TITLE (SPECIFY) M.D. <i>John S. Rogers</i> MEDICAL EXAMINER														
DATE SIGNED <i>November 1986</i>														
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 1919 Seminary Rd. Silver Spring, Md. 20910												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/23/86		23c. NAME OF CEMETERY OR CRÉMATORIUM Carmel Church Cemetery		23d. LOCATION CITY OR TOWN Carmel Church		23e. COUNTY Caroline		STATE Va.				
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR NOV 28 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Jackson-Randall</i>										
BP														
DHMH - 17 (VR A15 ME (5)) 15M 7/76														

Die erste Sitzung der Deutschen Akademie der Wissenschaften fand am 20. Februar 1952 statt.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM-3 RETAIN PAGE 3 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE EULOGIZED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												6 6 3 2 3 8								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR			
ANNA						ASPER						<input checked="" type="checkbox"/>		11/28	19	86	10 35 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	2d. HOUR	
FEMALE		White		2/14/1900		86 yrs.		MONTHS		DAYS		HOURS		MIN		11/28		1986		10 35 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.											
Syria			USA																	
10. CITY OR TOWN OF DEATH OLNEY			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
												Homemaker			own home					
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 4117 Queen Mary Dr. 20832											
14. FATHER'S NAME FIRST Elias			MIDDLE Nakles			15. MOTHER'S MAIDEN NAME FIRST Cecilia			Slyman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A			17. INFORMANT Joseph Asper-son- (same as 13e)			ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>																				
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> , and in my opinion																				
ACTUAL SIGNATURE <i>John S. Rogers</i>												TITLE (SPECIFY) M.D. <i>John S. Rogers</i> MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT)			John S. Rogers, DME									ADDRESS 1919 Seminary Rd. S.S. Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 2, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Blairsville Cemetery			23d. LOCATION CITY OR TOWN Blairsville			COUNTY			STATE					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			ADDRESS 11800 N.H. Ave. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR DEC 1 1986			25b. REGISTRAR'S SIGNATURE <i>Julia S. Rogers</i>											
BP																				
DHMH - 17 (VR A15 ME (5))																				
20M 4/B2																				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 6 3 2 3 8 8 3

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE THIS FORM TO FUNERAL DIRECTOR. PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PACES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Pauline</i>	MIDDLE -	LAST <i>Babest</i>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH 11 DAY 9 YEAR 1986 1521M	
1. SEX <i>f</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH 12 YEAR 1996	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 89	7. IF UNDER 1 YR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD <i>11/9/86</i> 1521M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Greece</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		
13a. STATE <i>md</i>	13b. COUNTY <i>Mont.</i>	13c. CITY OR TOWN <i>S11 Spa</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS <i>203 E. Schleyer Rd.</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>	
14. FATHER'S NAME FIRST <i>Elias</i>		MIDDLE 	LAST <i>Panagake</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Stamatiki</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>222-09-7166</i>		17. INFORMANT ADDRESS <i>Louis Babest son same as #13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Disi</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Chronic myocardial Disi</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)						
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>J. Rogers, M.D.</i>						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
TITLE (SPECIFY) <i>John J. Rogers, M.D.</i>						DATE SIGNED <i>Nov 9 1986</i>
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>1919 Seminary Rd., Silver Spring, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 12, 86</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Brentwood Prince Georges Md.</i>	23e. COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>		ADDRESS <i>500 University Blvd. West, Silver Spring, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1986</i>		25b. REGISTRAR'S SIGNATURE <i>ia Davidson Landau</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial/transit permit. Then please remove carbon copies 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical certifier must be advised at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 32384			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Christopher Earl BAKER						November 28, 1986			11:35 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE		Black		MONTH DAY YEAR			MONTHS DAYS			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS. MONTHS DAYS HOURS MIN.			
Silver Spring U.S.A.		U.S.		NOV. 28, 1986			MONTGOMERY			2 7			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
SILVER SPRING		HOLY CROSS HOSPITAL								n/a			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
WASH. D.C.										601, EDGEWOOD ST., N 703 20017			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			ADDRESS			LAST			
DENNIS				CHRISTINE			Christine Baker same as 13e			Marshall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
							prematurity extreme immaturity			within 24 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) probable fetal sepsis											
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 11-28-86, 19 86, to 11-28, 19 86, that <input type="checkbox"/> (we) lost saw the deceased alive on 11-28 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I) (we) did <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE KATHRYN L. WEISSE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/2/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHRYN L. WEISSE		22e. ADDRESS Holy Cross Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12/3/86		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN Silver Spring, Maryland						
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852								25a. DATE REC'D. BY REGISTRAR DEC 8 1986			25b. REGISTRAR'S SIGNATURE Julia Dawson-Landress		
DMH - 16 60M 7/B4 (MRA 15, 4)													

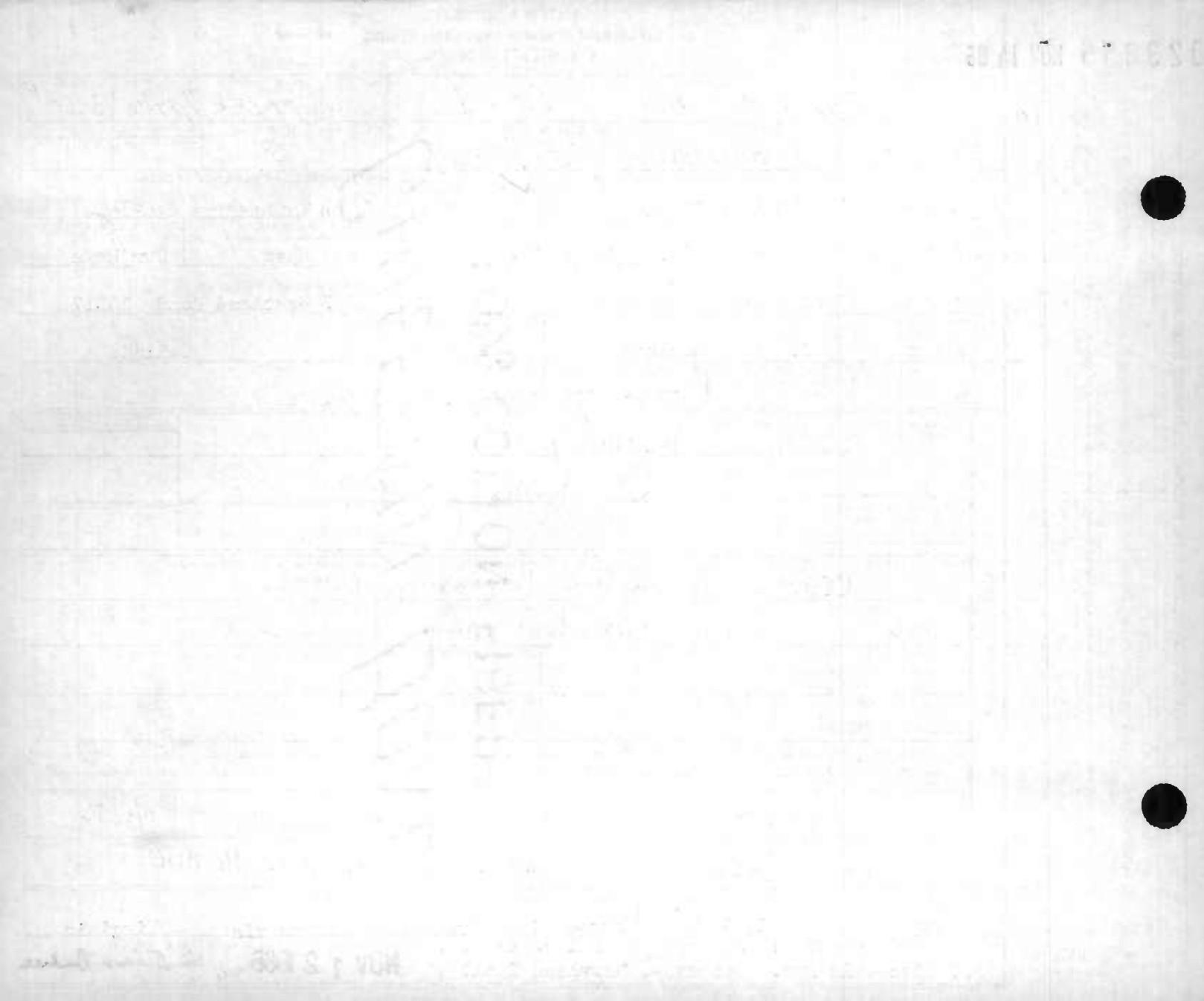
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 80 32390												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Elizabeth M. Bamel						NOVEMBER 7, 1986			5:50 P			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
Female		Caucasian		5 - 17 - 27			59 YRS.			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD		
Connecticut		United States					Montgomery County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital					Homemaker			Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Montgomery		Bethesda						6507 Westland Road 20817		
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Walter		R.		Rose						Sallade		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		577-36-8674		Louis M. Bamel same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest												
DUE TO, OR AS A CONSEQUENCE OF (b) Circumference of Lung												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Chronic Obstructive Pulmonary Disease.												
19a. DATE OF OPERATION 11/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy of mediastinal mass			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 1976 CITY OR TOWN 11/7 STATE MD							
22a. I certify that (I) (this hospital) attended the deceased from 19 1986, to 19 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE		DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/8/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Goode		22e. ADDRESS 4701 RANDOLPH Rd Rockville Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 8, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria			STATE Virginia		
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. NAME 7557 Wisconsin Ave. Bethesda, Maryland 20817		ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 12 1986			25b. REGISTRAR'S SIGNATURE Julia Dawson-Randall				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
MARGARET Peggy RANSAY					Barbour	November 1, 1986					1925M			
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
F			CAU.	MONTH DAY YEAR			64			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
SCOTLAND			USA			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTGOMERY			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
ROCKVILLE			Shady Grove Adventist			INSTRUCTOR.			TEACHING			20874		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD			MONTGOMERY			GERMANTOWN			19515 FREDERICK RD LOT 100					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
			unknown						unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			216-64-2829			EWAN G. BARBOUR, 7929 Spiceberry LANE, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>														
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.													(b) <u>Same</u>	
													(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CORONARY DISEASE, MALNUTRITION</u>														
19a. DATE OF OPERATION 10-27-86 10-12-86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMATOSIS</u> <u>FECAL FISTULA</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-2-86, 19_____, to 11-1-86, 19_____, that (I) (we) last saw the deceased alive on 10-1-86 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													22c. DATE SIGNED 11/1/86	
22b. SIGNATURE <u>Felix Flores</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FELIX FLORES</u>			22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 11/3/86			23c. NAME OF CEMETERY OR CREMATORIAL LEE'S CREMATORIAL			23d. LOCATION CITY OR TOWN WASHINGTON			COUNTY	STATE DC	
24. FUNERAL DIRECTOR NAME HYSONGS FUNERAL HOME			ADDRESS 320 E. DIAMOND, GAITHERSBURG MD			25a. DATE REC'D. BY REGISTRAR NOV 10 1986			25b. REGISTRAR'S SIGNATURE <u>Julia Frederica Radke</u>					

2021 RELEASE UNDER E.O. 14176

100-997M010

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITA. PAGE 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER. ALSO, PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A COPY OF THIS FORM IS TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PASS. IT IS TO BE FILLED OUT AND TURNED IN TO FUNERAL DIRECTOR. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												6	3	2	5	9	2			
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	WILLIAM	MIDDLE	L.	LAST	BARKER, SR.	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	7/26	9/26	M					
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			2c. DATE PRONOUNCED DEAD							
11. PLACE (STATE OR FOREIGN COUNTRY)		12. CITIZEN OF WHAT COUNTRY?			13. DATE RECORDED			14. CITY OR TOWN OF DEATH			15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			16a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12c. DATE RECORDED						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			12d. DATE RECORDED					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DATE OF OPERATION None			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b. TITLE (SPECIFY) John S. Rogers, MD			22c. MEDICAL EXAMINER			22d. DATE SIGNED Nov 22 1986		
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, DME			ADDRESS 1919 Seminary Road, S.S. Md.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Nov. 25, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery Brentwood Prince Georges Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS 11800 N.H. Ave., Hines/Rinaldi Funeral Home Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR NOV 25 1986			25b. REGISTRAR'S SIGNATURE Julia Deidra Landale												
DHMH - 17 (VR A15 ME (5))																				

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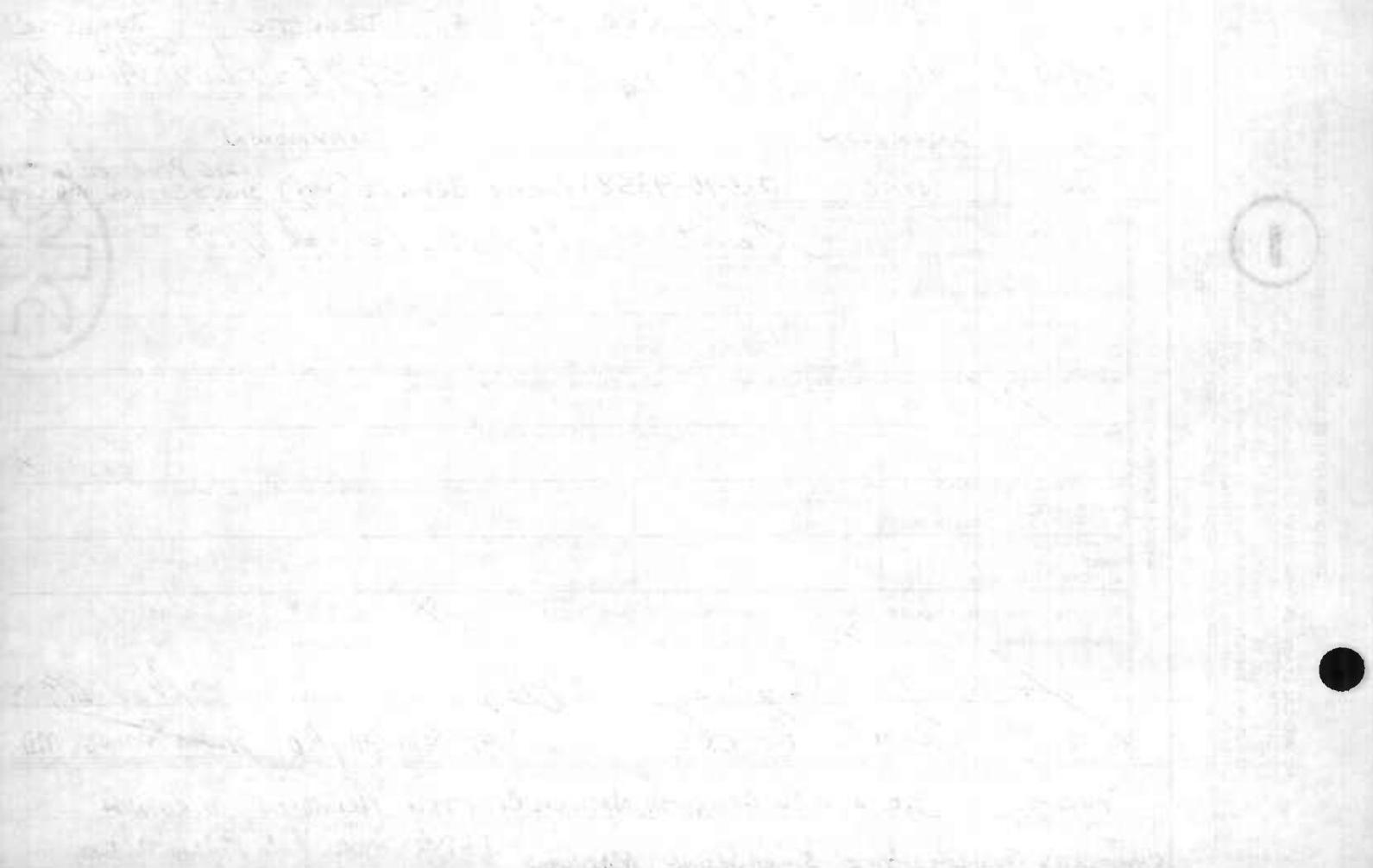


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												36	32	39	3			
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED DEATH			MONTH	DAY	YEAR	2b. HOUR			
Charlie Mae Beavers									Nov 26, 1986			19	08	7PM	M			
3. SEX:		4. RACE:		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS AT DEATH) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
F		W		Jan 8 13 79		79						Nov 26, 1986			19	08	7PM	M
7a. BIRTHPLACE ESTATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			Montgomery MD.						
MARYLAND			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring			20276-256th Ave Apt. 105			DOMESTIC			DOMESTIC									
USUAL RESIDENCE (IF HOMELESS HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13. STATE			13a. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Md			Md			Silver Spring						20910 201st Avenue Apt. 105						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
UNKNOWN			UNKNOWN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS												
(YES, NO OR UNKNOWN) NO			213-10-9358 Ronald Beavers (Son)			14216 PEAR TREE LA. #14 SILVER SPRING, MD. 20901												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>No acute myocardial infarct</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																		
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
19a. DATE OF OPERATION None																		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																		
ACTUAL SIGNATURE: <i>John S. Rogers</i>			M.D. <i>Cap</i>			TITLE (SPECIFY) <i>Medical Examiner</i>			DATE SIGNED <i>Nov 26, 1986</i>									
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			1919 Seminary Rd. Silver Spring, MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE					
BURIAL			Dec 2, 1986			Arlington National Cemetery Arlington, Virginia												
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Chambers Funeral Home			Silver Spring, Maryland			DEC 3 1986			Julia Davidson-Landree									

100102 100201

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32394

FOR
- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	
SAMUEL MAURICE BECKER						<input checked="" type="checkbox"/>	11	24	1986	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	
Male	White	June 10, 1905	81 yrs.	MONTHS DAYS	HOURS MIN.	11 24	1986	05 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey		U.S.A.					Montgomery County, MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		11420 Strand Drive, #414			Physician (Ret.) Medical					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	(20852) 11420 Strand Drive, #414			
Maryland		Montgomery		Rockville						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
Morris			Becker	Dora			(Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
Yes		WVI 579-66-9212			Miriam S. Becker: Wife; 11420 Strand Drive,		#414; Rockville, Md. 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11 24 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21e. LOCATION STREET CITY OR TOWN COUNTY STATE
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21e. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
EXAMINER'S NAME (TYPE OR PRINT)										TITLE (SPECIFY) Francis C. Mayo, M.D., Dept. of Pathology, Bethesda Hospital
EXAMINER'S SIGNATURE										DATE SIGNED 11/24/86
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 11/25/86		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Lebanon Cemetery			23d. LOCATION City or Town Adelphi; Montgomery; Maryland		23e. COUNTY State	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 25 1986			25b. REGISTRAR'S SIGNATURE John Danner, Registrar			
DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 Rockville Pike; Rockville, Md. 20852										

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DIVISION OF PUBLIC RECORDS DIRECTORATE BALTIMORE MARINA 10212

NO HOSPITAL OR ATTENDING PHYSICIAN: The

e executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove pages 1 and 2 should be retained with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMBRIANI. If team 21 is marked or team 18 shows any injury or other traumatic event

MEDICAL CERTIFICATION

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 2 8 9 1

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
MARY MAGDALENE BEGLEY							NOVEMBER 2, 1986				9:40p M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 2, 1924			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
							62		MONTHS DAYS		HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.							
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PENNSYLVANIA			13b. COUNTY Delaware		13c. CITY OR TOWN NORWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 27 WEST GARFIELD AVE 19074	
14. FATHER'S NAME FIRST Stephen		MIDDLE Boyce		15. MOTHER'S MAIDEN NAME FIRST Grace			MIDDLE		LAST McFadden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 196 -18-9435		17. INFORMANT MARY M. HOLKER (DAUGHTER) 1127 VILLANOVA AVE SWARTHMORE, PA 19081			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) SEVERE INTRAHEPATIC CHOLESTASIS, LIVER FAILURE							4 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) SEPSIS							3 years					
		(c) METASTATIC OVARIAN CANCER												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
RENAL FAILURE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
19a. DATE OF OPERATION		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21g. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/3/86								
22a. I certify that (X) this hospital attended the deceased from OCTOBER 14, 1986, to November 2, 1986, that (X) we lost saw the deceased alive on November 2, 1986, and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (X) we (did) (did not) view the body after death.		22b. SIGNATURE <i>Peter Q. Eichacker</i>		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-4-86		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION CITY OR TOWN Suitland, Maryland		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc. ADDRESS 1804 T Street, NW, Washington, DC 20009		25a. DATE REC'D. BY REGISTRAR NOV - 7 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Landree</i>										

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORWARDED TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE USED AS A BURIAL TRAITS SHEET. PAGES 5 AND 7 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 86 32395		
1. DECEASED NAME (TYPE OR PRINT)			FIRST FOSTER			MIDDLE E.			LAST BENNETT, Jr.			2a. DATE KNOWN OF ESTI- DEATH MADE	<input checked="" type="checkbox"/> MONTH 11-27-869 YEAR	2b. HOUR M
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT 15 1956		6. AGE (IN YEARS LAST BIRTHDAY) 30 yrs.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 11-27-869	2d. HOUR YEAR 3:30a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE Rooper		12b. KIND OF BUSINESS OR INDUSTRY Self-Emp.								
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS UNIVERSITY BLVD. 20902						
14. FATHER'S NAME First Foster		Middle E.		Last Bennett Sr.		15. MOTHER'S MAIDEN NAME First Lora		Middle		Last Dolly				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds (2) of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		17. INFORMANT Mark M. Gusacic		ADDRESS 1 Myrtle Ave Petersburg WVA 26897		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds (2) of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 2:10a.m. MON 27-86 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot by police		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET 10528 ST. Paul St. Kensington, Maryland		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street												DATE SIGNED 11-28-86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 30 NOV 86		23c. NAME OF CEMETERY OR CREMATORIAL BENNETT FAMILY CEMETERY		23d. LOCATION CITY OR TOWN ONEGO		COUNTY		STATE PENDLETON WVA				
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS ELLIOTT CITY MD 21043		25a. DATE REC'D. BY REGISTRAR DEC 2 1986		25b. REGISTRAR'S SIGNATURE John Deardon-Korell								
DHMH - 17 (VR A15 ME (5))														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 & 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 86 32391
1. DECEASED NAME (TYPE OR PRINT) Jeanette Bennett			2a. DATE OF DEATH MONTH DAY YEAR Nov. 16, 1986			2b. HOUR 11:28a
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1919	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 67 YRS			7. IF UNDER 24 HRS HOURS MIN. MD.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1400 Fenwick Lane, Apt. 611	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser			12b. KIND OF BUSINESS OR INDUSTRY Laundry	
13a. STATE MD	13b. COUNTY Montg.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1400 Fenwick Ln., #611/20910		
14. FATHER'S NAME FIRST Charlie Luckett	MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST Mary Brown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 459-26-1158	17. INFORMANT ADDRESS Lois James (niece) Silver Spring, MD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ① Diabetes Mellitus ② Hypertension						
19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 11-5	21f. LOCATION STREET 8580 Second Ave.			CITY OR TOWN Silver Spring	COUNTY Montgomery
22a. I certify that (I) (this hospital) attended the deceased from 11-5, 1985, to 11-16, 1986, that (I) (we) last saw the deceased alive on 11-5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (s)he died in (s)he) view the body after death.						
22b. SIGNATURE Thomas J. Locke, III, M.D.						
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J. Locke, III, M.D.	22d. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED 11/21/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-22-86	23c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial Cem.			23d. LOCATION CITY OR TOWN Sandy Spring, Montg.	
24. FUNERAL DIRECTOR NAME George R. Snowden						
25a. DATE REC'D. BY REGISTRAR NOV 25 1986						
25b. REGISTRAR'S SIGNATURE Julie Davidson-Rendall						

(1)

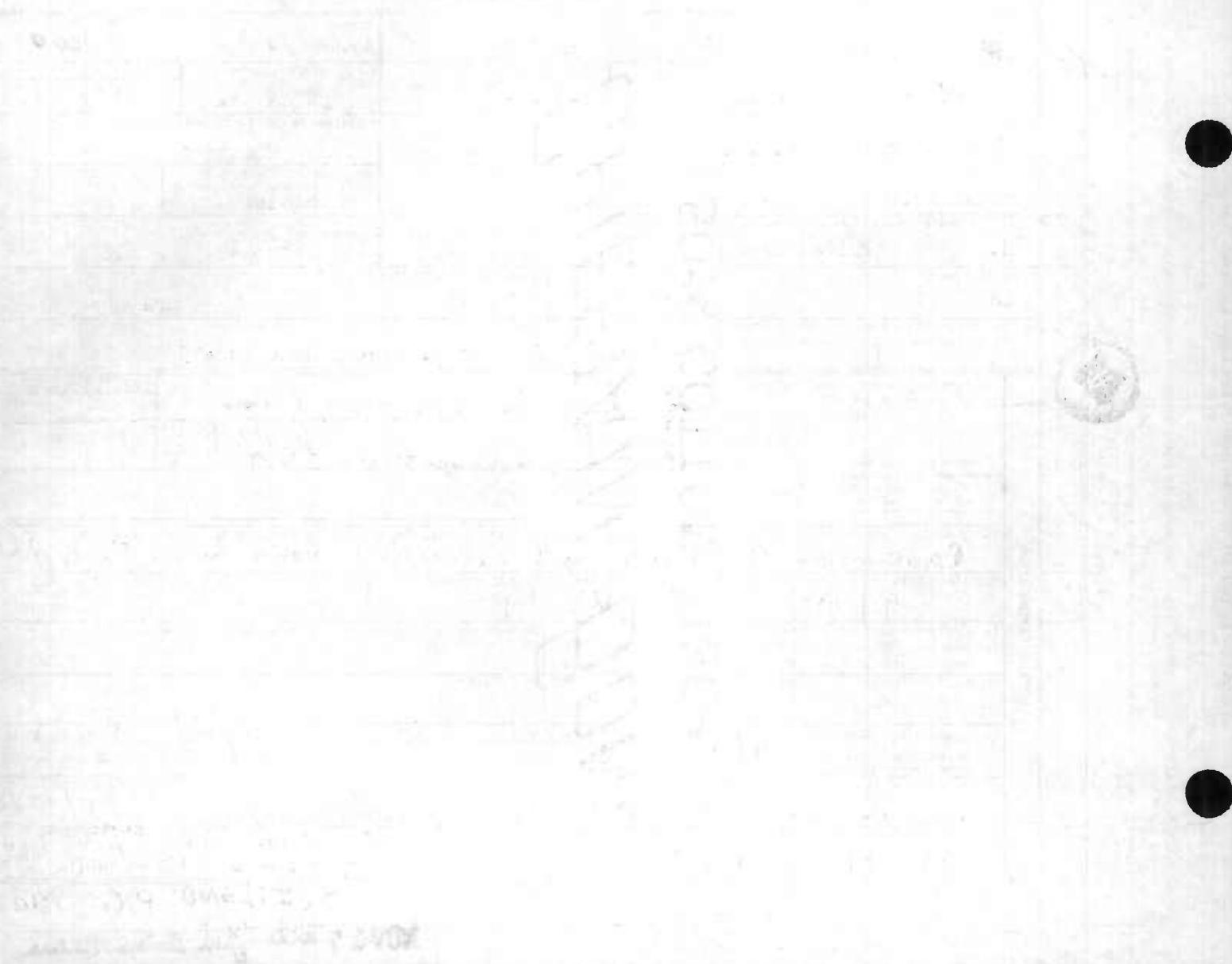
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial/transit permit. Then please remove card with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Item 18 shows any injury, or other traumatic condition which may affect the cause of death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic condition which may affect the cause of death, attach a separate sheet of paper and describe the condition in detail.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>John</i>			<i>C</i>	<i>Benton</i>			<i>November 12 1986</i>						<i>00 05 AM</i>		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
<i>M Male</i>			<i>White</i>		<i>MONTH 1-30-1904 DAY</i>		<i>YEAR</i>			<i>82 XX</i>	<i>82 yrs.</i>	<i>MONTHS</i>	<i>DAYS</i>	<i>HOURS</i>	<i>MIN.</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
<i>North Carolina</i>			<i>U.S.A.</i>				<i>XEMI Montgomery</i>								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
<i>Takoma Park</i>			<i>Washington Adventist</i>		<i>Machinist</i>										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md.			13c. CITY OR TOWN <i>Prince Georg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>2414 Cherokee St 20783</i>								
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
<i>Lee</i>				<i>Benton</i>	<i>Eureetta</i>				<i>Gregory</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Cecelia B. Benton same as #13			ADDRESS							
<i>NO</i>			<i>577-62-3336</i>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <i>A Aspiration Pneumonia, e cee</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary, and massive CVA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Aspiratory failure</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Carcinoma of prostate with mets in bone, Renal failure, Fr. hip (L)</i>															
19a. DATE OF OPERATION <i>9/15/86</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fr. (L) hip</i>			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 11, 1986</i> , to <i>Nov. 12, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>A. A. Chacko</i>			DEGREE <i>mp</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/12/86</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. A. CHACKO</i>			22e. ADDRESS <i>7610 Carroll Ave Suite 390 Takoma Park MD 20912</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE <i>11-13-1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Washington National</i>		23d. <i>SCHILLAND CO. P.C. Md.</i>								
24. FUNERAL DIRECTOR NAME <i>Donald V. Borgwardt</i>			ADDRESS <i>4400 Powder Mill Rd. Beltsville Md.</i>		25. APPROVED BY FUNERAL DIRECTOR, REGISTRATION SIGNATURE <i>[Signature]</i>										

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

THE HISTORICAL PERSPECTIVE

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for the **BURIAL FINGERPRINT PERMIT**. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Depts. of Health and Mental Hygiene or the County Health Department.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 32392

1. DECEASED NAME (TYPE OR PRINT) Allen H Bergman			REG. NO.
FIRST		MIDDLE	LAST
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Dec. DAY 19 YEAR 1915	2a. DATE OF DEATH MONTH DAY YEAR November 8, 1986
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) 70 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery
13a. STATE Maryland		13b. COUNTY Montg.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor (Ret)
13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12b. KIND OF BUSINESS OR INDUSTRY Home Remodeling
14. FATHER'S NAME FIRST Jacob MIDDLE Bergman LAST		15. MOTHER'S MAIDEN NAME Julia	20760
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 130-03-2166	17. INFORMANT Gaithersburg, Md., 20760 Gertrude Bergman; 19227 Dunbridge Way
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) lung mass			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I o			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/8/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		21g. CITY OR TOWN	COUNTY STATE
22b. SIGNATURE <i>Mary H. Fang, MD</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/8/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary H. Fang, MD	22e. ADDRESS 11004 Round Table Ct. Rockville, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-10-1986	23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden	23d. LOCATION Falls Church, Virginia
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike	25a. ADDRESS Rockville, Maryland	25b. DATE REC'D. BY REGISTRAR NOV 12 1986	25c. REGISTRAR'S SIGNATURE <i>Karen Deidra Pendleton</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified in due time.

6
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified in due time.

024426 NOV 10-86

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 32400

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST RAE	MIDDLE	LAST BERKMAN	20. DATE OF DEATH November 13, 1986	MONTH NOVEMBER	DAY 13	YEAR 1986	2b. HOUR 6:10 AM	
3. SEX Female				4. RACE White	5. DATE OF BIRTH MONTH October YEAR 1892		6. AGE (IN YEARS LAST BIRTHDAY) 94		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia				7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 916 Clintwood Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE Md.				13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 916 Clintwood Drive 20902				
14. FATHER'S NAME FIRST Abraham				MIDDLE	LAST Epstein	15. MOTHER'S MAIDEN NAME FIRST Rose		16. ADDRESS LAST Goodman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 225-05-3462D		17. INFORMANT Albert Berkman (Same as # 13)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				cardiac respiratory arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) congestive heart failure				days				
				(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (1) this hospital attended the deceased from September 19, 1979 to November 19, 1986, that (2) we last saw the deceased alive on November 11, 1986, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (1) we did (did not) view the body after death.												
22b. SIGNATURE Marian M. Chung, M.D.						DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Nov. 13, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marian M. Chung, M. D.			22e. ADDRESS 4701 Randolph Rd. # 102, Rockville, Md. 20852									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/14/1986	23c. NAME OF CEMETERY OR CREMATORIAL King David Mem. Garden			23d. LOCATION Fallen Church, Virginia					
24. FUNERAL DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR NOV 17 1986		25b. REGISTRAR'S SIGNATURE John Deacon-Landree				

2011-03-15

2011-03-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be countersigned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-transit permit. Then please remove carbon paper from the back of this page and attach it to the burial-transit permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32401 10:15			
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Ely</i>	MIDDLE	LAST <i>Bernstein</i>	20. DATE OF DEATH MONTH DAY YEAR <i>11 18 86</i>	MONTH <i>NOV</i>	DAY <i>25</i>	YEAR <i>1986</i>	REG. NO. <i>10/5A</i>	26. HOUR <i>10/5AM</i>			
3. SEX <i>M ALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 8 98</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY COUNTY MD.</i>							
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hebrew Home of GREATER WASH.</i>		12a. USUAL OCCUPATION <i>SALESMAN</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>WHLSE DIST.</i>		APT. 204 21215					
13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6624 VINCENT LA.</i>					
14. FATHER'S NAME FIRST <i>Joseph</i>		MIDDLE	LAST <i>Bernstein</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Hinda</i>		MIDDLE <i>LENA</i>	LAST <i>Lillian</i>	UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>23 05 2763</i>		17. INFORMANT <i>MRS. FLORENCE SINGER</i>		ADDRESS <i>30 BARTHEL CT. LUTHERVILLE MD 21093</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> (c) <i></i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>DEPRESSION</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/17</i> to <i>11/18</i> , 19 <i>86</i> , to <i>11/18</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>11/17</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) rule the body after death.													
22b. SIGNATURE <i>Alan Chanael</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED <i>11/18/86</i>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALAN CHANAEL</i>		22g. ADDRESS <i>1525 SHADY GROVE RD. ROCKVILLE</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>NOV. 19, 1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>BETH ISAAC ADATH ISRAEL</i>		23d. LOCATION CITY OR TOWN <i>BALTIMORE</i>		COUNTY		STATE <i>MARYLAND</i>			
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 25 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									
6010 REISTERSTOWN RD. BALTO., MD 21215													

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use as you

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

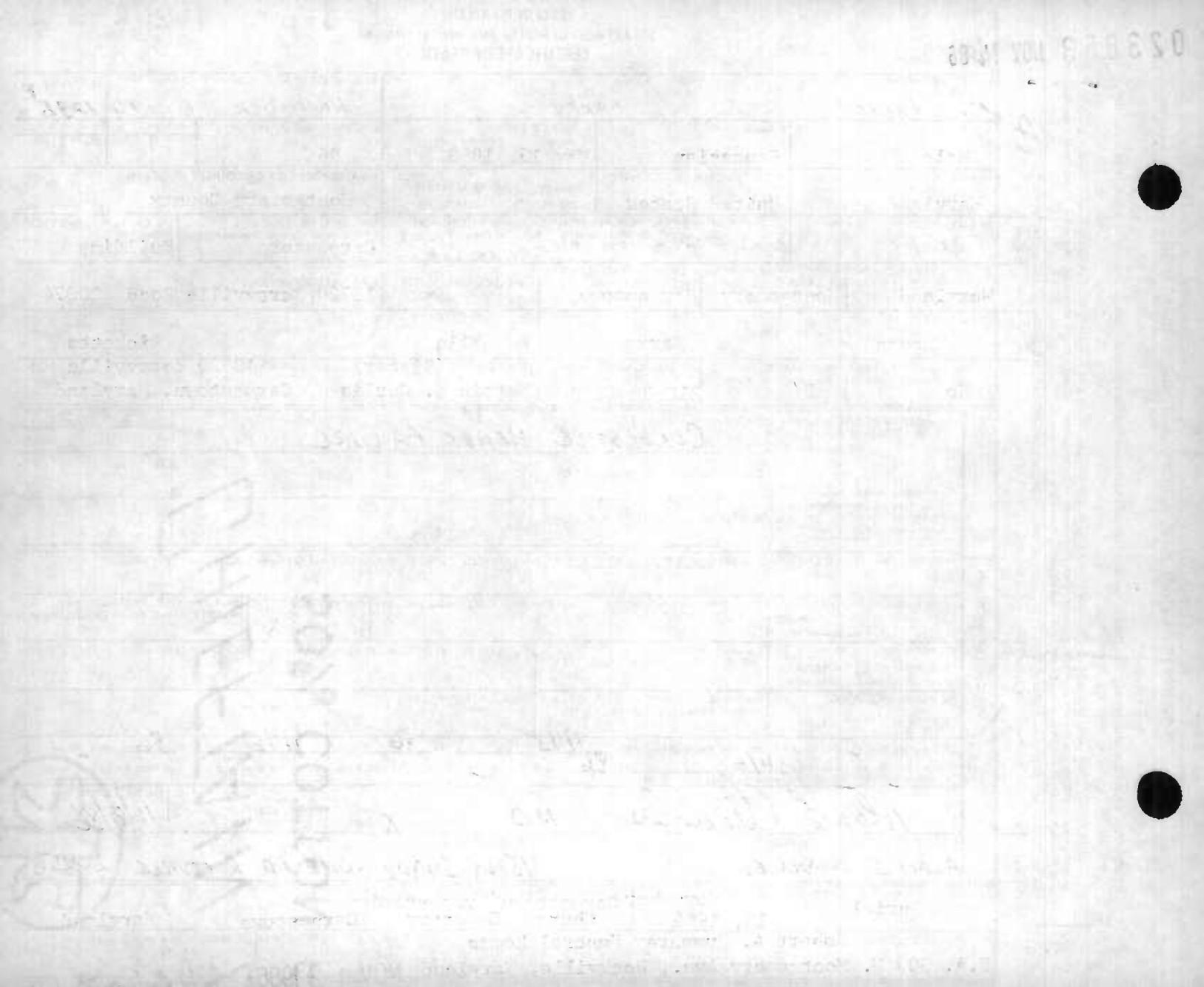
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						86 32402						
						REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
W. ERNEST			BERRY	November	6	1986	12:55 P.M.					
2. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.			
Male	Caucasian	MONTH	DAY	YEAR	96	YRS.						
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland	United States				Montgomery County							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Rockville	Shady Grove Hospital 9901 Medical Center Dr.					Carpenter			Building			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland	Montgomery	Germantown				13720 Berryville Road			20874			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
Thomas			Berry	Elia						Ricketts		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT (SISTER)			ADDRESS						
No	N/A		Mattie E. Curlis			13720 Berryville Rd			Germantown, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/15/86 to 11/16/86, that (I) (we) last saw the deceased alive on 11/16/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 11/16/86		
22b. SIGNATURE Alan S. Chanales										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/16/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN S. CHANALES										22e. ADDRESS 15225 SHADY GROVE RD ROCKVILLE 20850		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION CITY OR TOWN			COUNTY	STATE					
Burial	November 10, 1986	Darnestown Presbyterian Church Cemetery	Darnestown			Maryland						
24. FUNERAL DIRECTOR NAME P.A. 300 W. Montgomery Ave., Rockville, Maryland	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE NOV 12 1986					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completely. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 32403

025823 DEC

1. DECEASED NAME SANDRA JEAN BETZ			FIRST SANDRA	MIDDLE Jean	LAST BETZ	2a. DATE OF DEATH November 26, 1986	MONTH NOVEMBER	DAY 26	YEAR 1986	2b. HOUR 3:30A M
3. SEX Female			4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 20, 1937	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio			7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6304 Owen Place		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Montgomery Co. Schools			
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6304 Owen Place / 20817				
14. FATHER'S NAME FIRST Willard			MIDDLE A.	LAST Montgomery	15. MOTHER'S MAIDEN NAME FIRST Hazel	MIDDLE	LAST McKirahan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - 301-32-3499		17. INFORMANT Mr. John H. Betz, Ex-husband, Suite 400, 2300 M. Street, N.W. Wash., D.C.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Metastatic Adenocarcinoma of the Liver, Primary Unknown					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b)							
			DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from November 20, 1986, to November 26, 1986, that (I) (we) last saw the deceased alive on November 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Albert Rolle, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED November 26, 1986				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert Rolle, M.D.		22e. ADDRESS 1140 Varnum Street, N.E. Washington, D.C. 20017								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE November 26, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria		23e. COUNTY Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 1 1986		25b. REGISTRAR'S SIGNATURE <i>Lia Reid</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use on the burial permit. Then please remove carbon copies. Please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked on item B shows any injury, or other traumatic event, file medical records with the State Dept. of Health and Mental Hygiene.

NOV 19 86
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 3 2 4 0 4

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
ALMA					BIGGERS	11-4-86	11	4	86	8:50 A.M.			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Female			Black	MONTH	DAY	YEAR	55	IF UNDER 24 HRS			8. IF UNDER 24 HRS		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
South Carolina			U.S.A.						Montgomery			Private Family	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda			Suburban Hospital			Private Family							
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			999999	
D.C.			Washington						549-45th Street, N.E.			20019	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS			LAST		
Fletcher				Fogle	Lurline			549-45th Street, N.E.			Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			251-34-9851			George Biggers							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>severe coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes, anemia</u>													
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) saw the deceased alive on <u>11-7-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>11-26-86</u> to <u>11-4-86</u> , that (I) (we) last saw the deceased alive on <u>11-7-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Hadi Bahar</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HADI BAHAR</u>			22e. ADDRESS <u>8218 Wisconsin Dr. Bethesda MD</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11/9/86	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive Cemetery			23d. LOCATION CITY OR TOWN Santee			CITY OR TOWN Orangeburg			STATE S.C.
24. FUNERAL DIRECTOR <u>Rollins J.H.</u>			ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E.			25a. DATE REC'D. BY REGISTRAR NOV 12 1986			25b. REGISTRAR'S SIGNATURE <u>Juliann Johnson</u>				
WASHINGTON, D.C. 20019													

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999999
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20 71 101 104 100

transcription

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Final editing

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Editing

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

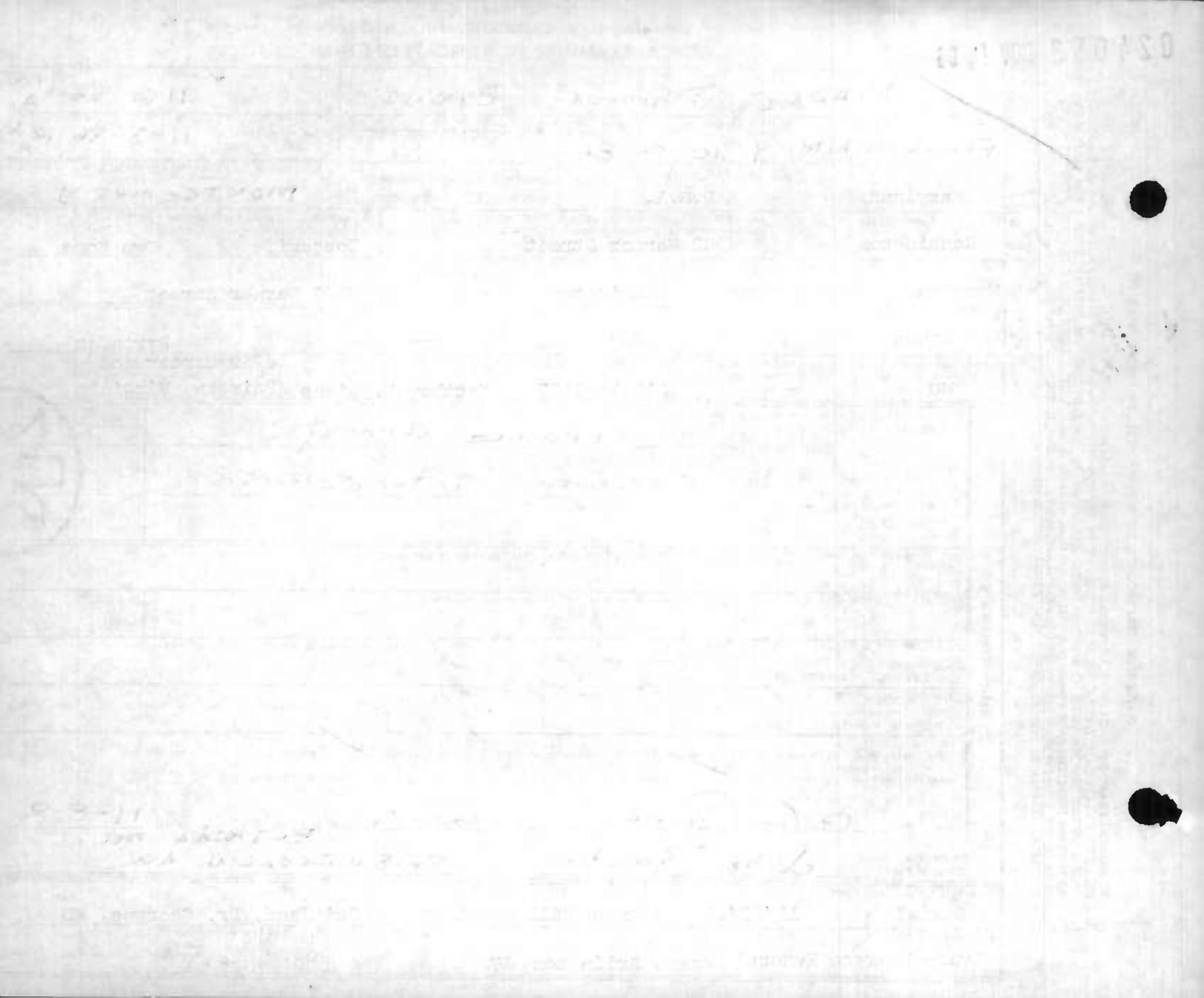
32405

024053 NOV 1 1986

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, RETAIN IT UNTIL 24 HOURS HAVE PASSED, THEN FORWARD TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3, RETAIN IT UNTIL 30 DAYS HAVE PASSED, THEN FORWARD TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.		<p style="margin: 0;">3 2 4 0 5</p>	
<small>FOR STATE REGISTRAR</small> <small>TYPE OR PRINT</small>		MADGE Therese BINNS	
I. DECEASED NAME <small>FIRST MIDDLE LAST</small>		2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2b HOUR DEATH MATED <input type="checkbox"/> 11 8 86 1 PM	
1a SEX: <input checked="" type="checkbox"/> Female RACE: <input checked="" type="checkbox"/> White	5. DATE OF BIRTH <small>MONTH DAY YEAR</small> 9 10 00	6. AGE (IN YEARS LAST BIRTHDAY) <small>MONTHS DAYS HOURS MIN</small> 86 YRS.	7. IF UNDER 1 YR. <small>MONTHS DAYS HOURS MIN</small> IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
10 CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4302 Warner Street	
12a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE: Maryland		13b COUNTY: Montgomery	
13c CITY OR TOWN: Kensington		13d INSIDE CITY LIMITS? <small>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small> 13e STREET ADDRESS 4302 Warner Street	
14. FATHER'S NAME <small>FIRST MIDDLE LAST</small> James E. Eddy		15. MOTHER'S MAIDEN NAME <small>FIRST MIDDLE LAST</small> Mary Byroades	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES, NO, OR UNKNOWN) <input type="checkbox"/> NO</small>		16b. SOCIAL SECURITY NO. 213-74-5837	
17. INFORMANT Matthew F. Binns		4752 Carterwood Fairfax, Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <small>DUE TO, OR AS A CONSEQUENCE OF</small> <small>Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u></small> (b) <small>DUE TO, OR AS A CONSEQUENCE OF</small> <small>Coronary Arteriosclerosis</small> (c)			
<small>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</small>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <small>P.M. 19</small>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <small>John Fauber</small>	
21f. LOCATION STREET		21g. CITY OR TOWN <small>John Fauber</small>	
21h. COUNTY		21i. STATE	
22a. I certify that I took charge of the remains described above, held an <small>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/></small> <small>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></small>			
ACTUAL SIGNATURE <small>John Fauber</small>		TITLE (SPECIFY) <small>M.D. Deputy Medical Examiner</small>	
EXAMINER'S NAME (TYPE OR PRINT) <small>John Fauber</small>		DATE SIGNED <small>11-8-86</small>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/11/86	
23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland, Prince Georges, MD	
24. FUNERAL DIRECTOR <small>NAME</small> Ives- Pearson Funeral Homes, Arlington, VA		25a. DATE REC'D. BY REGISTRAR JULY 14 1986	
25b. REGISTRAR'S SIGNATURE <small>Julia Fauber-Randall</small>			

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executed within 24 hours after death. Page 4 may be

HOSPITAL OR ATTENDING PHYSICIAN. The

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

3 6 3 2 4 0 3

1. DECEASED NAME (TYPE OR PRINT) Walter C. Bishop			REG. NO.
FIRST MIDDLE		LAST	2a. DATE OF DEATH MONTH DAY YEAR November 10, 1986
3. SEX Male		4. RACE Caucasian	2b. HOUR 10:00pm
5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1882		6. AGE (IN YEARS LAST BIRTHDAY) 103 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13305 Glen Mill Road/20850	
14. FATHER'S NAME FIRST Samuel		MIDDLE F.	LAST Bishop
15. MOTHER'S MAIDEN NAME Sarah			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A	17. INFORMANT ADDRESS Mildred E. Cannon, same as #13
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1</u> , 19 <u>83</u> , to <u>Nov. 10</u> , 19 <u>86</u> , that (II) (we) lost saw the deceased alive on <u>Oct. 10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Frauke Westphal MD</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Nov. 11, 1986
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal, M.D.	22e. ADDRESS 809 Viers Mill Road Rockville, Maryland 20851		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 13, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park	23d. LOCATION CITY OR TOWN Rockville, Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, PA 300 West Montgomery Ave. Rockville, MD 20850	25a. ADDRESS 300 West Montgomery Ave. Rockville, MD 20850	25b. DATE REC'D. BY REGISTRAR	25c. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

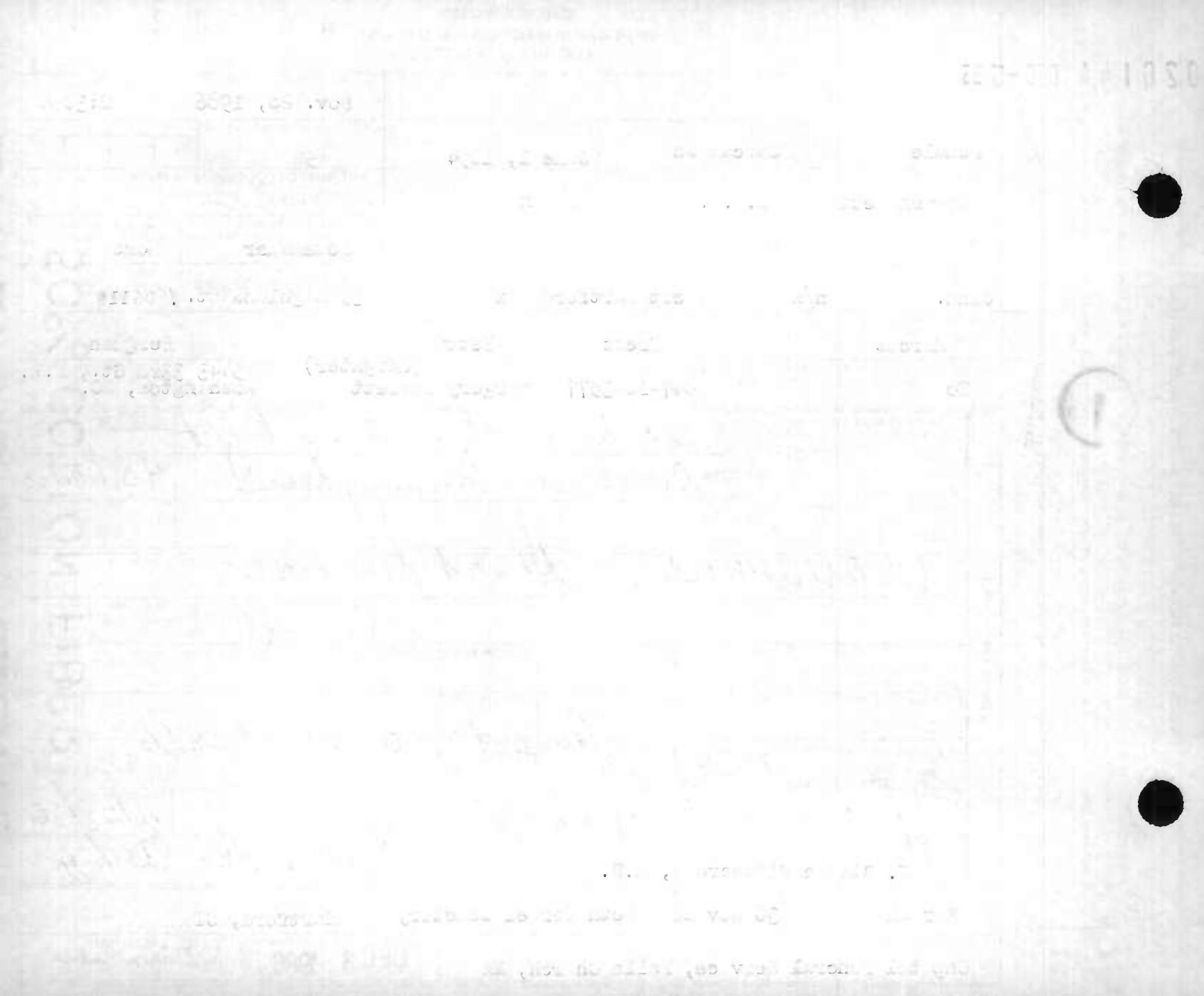
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, then medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32401			
										REG. NO.			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR										
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			Nov. 28, 1986							
SARAH H. BLECH										2b. HOUR 2:30 A.M.			
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. DATE OF DEATH MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			June 1, 1894			92 YES			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CARRIAGE HILL BETHESDA			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			13b. KIND OF BUSINESS OR INDUSTRY Home				
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Conn. 13a. COUNTY n/a			13c. CITY OR TOWN West Hartford			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 39 Highland St. / 06119			MD	
14. FATHER'S NAME FIRST MIDDLE LAST Marcus Press			15. MOTHER'S MAIDEN NAME MIDDLE LAST Yetta Bergman										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (If Yes, Give War Dates)			16b. SOCIAL SECURITY NO 047-10-3577			17. INFORMANT (daughter) ADDRESS Margery Passett 5441 33rd St., N.W. Washington, DC.							
18. CAUSE OF DEATH (Enter only one cause per line for item 18, 19, 20 & 21) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Cerebral thrombosis right						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b)			48 hours.										
DUE TO, OR AS A CONSEQUENCE OF (b)			Cerebral hemisphire										
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, identify medical examiner)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (in) this hospital attended the deceased from <u>August 82</u> to <u>November 86</u> that (in) two (2) hours the deceased died on <u>Nov. 27, 1986</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. I (have) (did) (not) view the body after death.										22b. DATE SIGNED <u>11/28/86</u>			
22c. SIGNATURE <u>J. Blaine Fitzgerald, M.D.</u>			22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.			22f. ADDRESS 8218 Wisconsin Ave. Bethesda, MD										
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 30 Nov 86			23c. NAME OF CEMETERY OR CREMATORIAL Beth Israel Cemetery			23d. LOCATION CITY OR TOWN Hartford, CT			COUNTY STATE	
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA										25a. DATE REC'D. BY REGISTRAR DEC 3 1986		25b. REGISTRAR'S SIGNATURE <u>Julie Carlson-Lindner</u>	

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32408			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Francis		MIDDLE O.	LAST Bliss Jr.		2a. DATE OF DEATH		MONTH November	DAY 8	YEAR 1986	2b. HOUR 7:11 pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
				MONTH January DAY 21 YEAR 1925		61 YRS		MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		P. O Box 8340		12b. KIND OF BUSINESS OR INDUSTRY Glass Business			
14. FATHER'S NAME FIRST Francis		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Dorothy		MIDDLE	LAST Cole						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 219-12-4532		17. INFORMANT Mrs. Deborah Burns, 27 Gold Kettle Ct. Gaithersburg, Maryland 20878		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal bleeding; acute hemorrhagic pancreatitis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis													
DUE TO, OR AS A CONSEQUENCE OF Severe atherosclerosis, old myocardial infarction with aneurysmatic dilatation													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (his hospital) attended the deceased from November 4, 1986, to November 8, 1986, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 8, 1986, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.										22c. DATE SIGNED 11/10/86			
22b. SIGNATURE <i>JAY H. HOOFNAGLE</i>										DEGREE			
22d. PHYSICIAN'S NAME JAY H. HOOFNAGLE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 11/10/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11-10-86		23c. NAME OF CEMETERY OR CREMATORIAL STATE ANATOMY BOARD		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME STATE ANATOMY BOARD										25a. DATE REC'D. BY REGISTRAR NOV 17 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Johnson-Randall</i>	
ADDRESS PATTTMORPE, MD.													
DHMH - 16 60M 7/84 (VRA 15, 4)													

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RECEIVED
U.S. DISTRICT COURT
CLERK'S OFFICE
WICHITA, KANSAS

TO HOSPITAL OR ATTENDING PHYSICIAN The
attained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The state medical examiner or coroner should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal.

IMPROVING K-12 INSTRUCTION THROUGH HISTORICAL PERSPECTIVE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 2 4 0 9

REG NO

1. DECEASED NAME (TYPE OR PRINT) Nellie R. Bishoff			2. DATE OF DEATH MONTH DAY YEAR 11 30 86	3. MONTH DAY YEAR 10:20 AM
4. SEX Female	5. RACE Caucasian	6. DATE OF BIRTH MONTH DAY YEAR March 14, 1902	7. AGE (IN YEARS LAST BIRTHDAY) 84	8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	10. CITIZEN OF WHAT COUNTRY? United States	11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
13. CITY OR TOWN OF DEATH Bethesda	14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	16. KIND OF BUSINESS OR INDUSTRY Automotive Repair	
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 18. STATE Maryland			19. COUNTY Montgomery	20. CITY OR TOWN Bethesda
21. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	22. STREET ADDRESS / ZIP CODE 6021 McKinley Street / 20817			
23. FATHER'S NAME FIRST Hugh	MIDDLE Duff	24. MOTHER'S MAIDEN NAME FIRST Catherine	MIDDLE Harper	
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	26. SOCIAL SECURITY NO. 167-05-8280	27. INFORMANT Mrs. Marilyn W. Hicks, Daughter, Same as #13	28. ADDRESS	
29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>			30. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) _____				
DUE TO, OR AS A CONSEQUENCE OF c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
31a. DATE OF OPERATION	31b. CONDITION FOR WHICH OPERATION WAS PERFORMED	31c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	31d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
32a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	32b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	32c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)		
33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	35. LOCATION STREET CITY OR TOWN COUNTY STATE		
36. I certify that (I) (in this hospital) attended the deceased from <u>July</u> , 19 <u>85</u> , to <u>Nov</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Nov 20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.				
37. SIGNATURE <i>Galen Hallick</i>	DEGREE <i>M.D.</i>	38. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	39. DATE SIGNED <i>11/30/86</i>	
40. PHYSICIAN'S NAME (TYPE OR PRINT) GALEN HALICK	41. ADDRESS 11125 Rockville Pike, Rockville, MD.			
42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	43. DATE December 3, 1986	44. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery	45. LOCATION CITY OR TOWN Brentwood	
46. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Avenue, Bethesda, MD.	47. ADDRESS 	48. DATE REC'D. BY REGISTRAR DEC 2 1986	49. REGISTRAR'S SIGNATURE <i>Julia Swanson-Lundquist</i>	

08112000

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner may be notified or access

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 32410

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
JOHN			William	BLUM		11-13-86				5 20 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Month Day Year February 25, 1898		88		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Boston, Mass.		U.S.A.				Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				Accountant (Ret.) Self-Employed					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Silver Spring				1819 Snowdrip Lane (20906)			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
William			Blum	Phoebe			Aarons				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Unknown		022-09-4760		Norman Blum; Son; 1819 Snowdrop Lane; Silver Spg		Maryland 20906				2-3 MIN.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DISEASE UNKNOWN											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b UNDEFINED BILATERAL PULMONARY Parenchymal Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from Nov. 12 1986 to Feb. 19 1987 , to Nov. 19 1986 , that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lawrence D. Marcus, M.D. DEGREE D.O. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED 11/13/86											
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
LAWRENCE D. MARCUS, M.D.		10313 GEORGIA AVE., S. S. MD 20902									
23a. BURIAL, CREMATION, REMOVAL SPECIES		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY			
Burial		11/18/86		HAND-IN-HAND CEMETERY		West Roxbury, Massachusetts					
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DANZANSKY-GOLDBERG MEMORIAL CHPLS. 1170 Rockville Pike; Rockville, Md. 20852											
25c. ADDRESS											
NOV 1 1986											

CLEARED BY DR. TAUBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death.

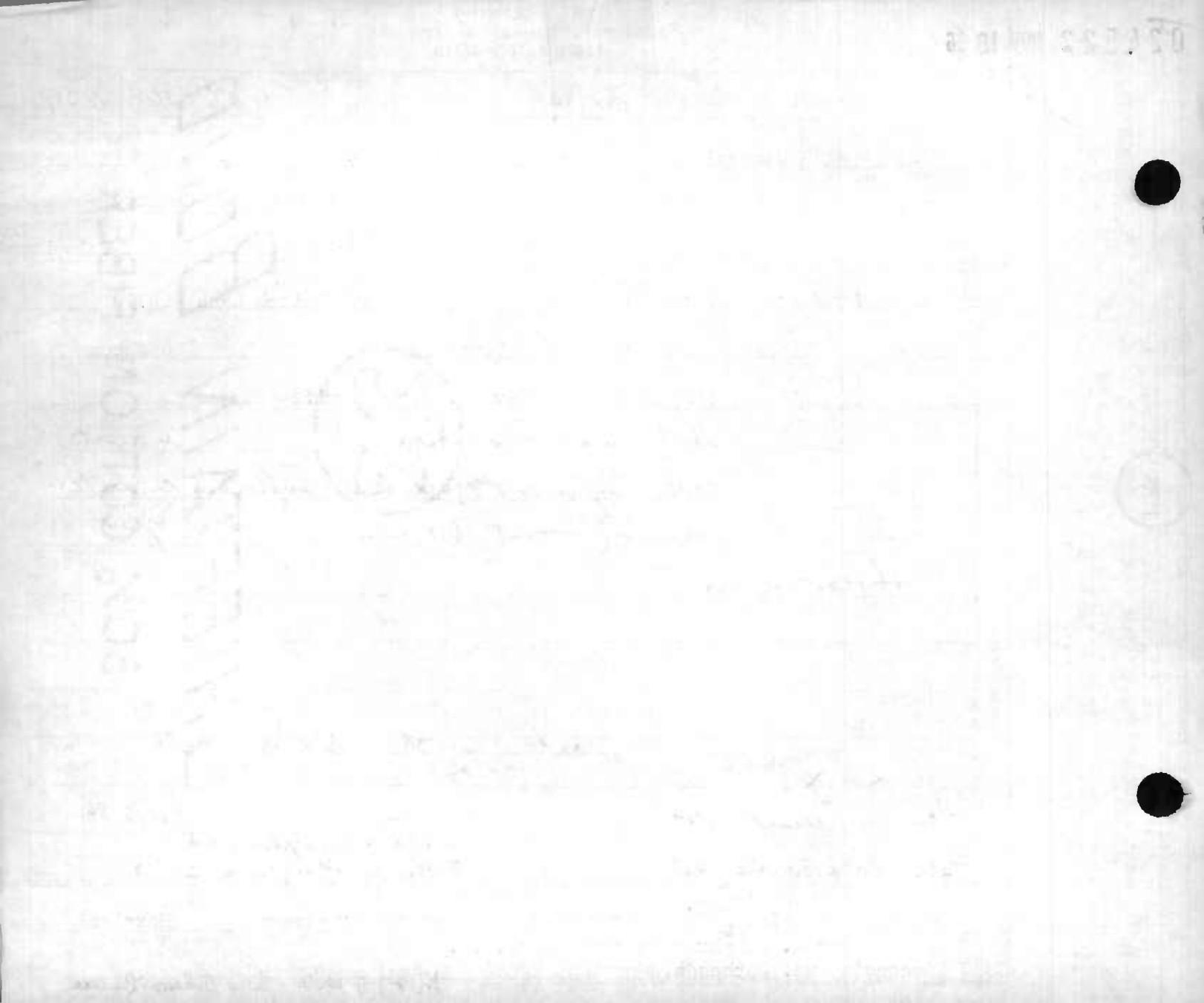
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
Richard L. Bogley						11	6	86	6:31 pm			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Male		Caucasian		April 10, 1921		65 YRS.						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		United States				Montgomery County,						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		Co.				
Bethesda		Suburban Hospital		Service Foreman		C & P Telephone						
13a. STATE Maryland						13b. COUNTY Anne Arundel						
13c. CITY OR TOWN Tracy's Landing						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Samuel Walter Bogley						Virginia Houghton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
Yes WW II		577-16-0213		Olive M. Bogley wife same as 13								
18. CAUSE OF DEATH Enter only one cause per line for item (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Ventricular Fibrillation						minutes						
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Inferior Myocardial Infarction						minutes						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease						years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from <u>May 29</u> , 19 <u>86</u> , to <u>No 6</u> , 19 <u>86</u> , that (1) (X) last saw the deceased alive on <u>May 29</u> , 19 <u>86</u> , and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above. (1) (I did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
Harold C. Lewis MD												11/6/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			10401 Old Georgetown Rd			Bethesda Maryland 20814			
Harold C. Lewis MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY		COUNTY	STATE	
Burial		Nov. 10, 1986		Fort Lincoln Cemetery		Brentwood						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Robert A. Pumphrey Funeral Homes, P.A.												
7557 Wisconsin Ave. Bethesda, Maryland 20814												
BP												
DHMH - 16 60M 7/B4 (VRA 15, 4)												
NOV 17 1986												
John S. Johnson, Landau												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please attach this paper to the death certificate. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 324	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH		MONTH	DAY	YEAR	7b. HOUR	
Mary		R.	Booth		November		13,	1986		7:15 A.M.	
3. SEX		RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			IF UNDER 24 HRS	
F		Caucasian	MONTH	DAY	YEAR	56 yrs	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.						Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital		Underwriter		Insurance					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		10806 Tenbrook Drive		20901	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		Arthur	W.	Cross			Marie			Cosgrove	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no		579-32-3881		Harry M. Booth		husband		same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Emboli											
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Cancer											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/26, 1986, to 11/13, 1986, that (I) (we) last saw the deceased alive on 11/11, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE _____ DEGREE _____											
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/13/86									
22e. ADDRESS 344 University Blvd. W., Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Nov. 17, 86		23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery		23d. LOCATION CITY/TOWN Silver Spring		COUNTY Montgomery		STATE Md.	
24. FUNERAL DIRECTOR Francis J. Collins, Jr. NAME 500 University Blvd. West, Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR NOV 21 1986		25b. REGISTRAR'S SIGNATURE June Dawson-Landale							
DHMH - 16 60M 7/84 (VRA 15, 4)											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **SAVED**, show age, injury, or other traumatic event. The medical examiner must be advised of all such events.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						863241				
1 - FOR STATE REGISTRAR						REG. NO.				
2a. RELEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
SAMUEL CHARLES BORZILLERI				11	13	86		4:45A M		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
MALE	CAUCASIAN	8	MONTH	23	DAY	74	MONTHS	IF UNDER 24 HRS		
YEAR		YEAR		YRS.		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
NEW YORK	UNITED STATES				MONTGOMERY					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	NAVAL HOSPITAL BETHESDA					RETIRED				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MARYLAND	MONTGOMERY	Kensington				9523 CABLE DRIVE 20895				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST		
FRANK			BORZILLERI	ANNA				POLITO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
YES	1941-1944	ELEANOR BORZILLERI			Same as item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENO CARCINOMA OF LUNG										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5 NOVEMBER 1986 to 13 NOVEMBER 1986, that (I) (we) last saw the deceased alive on 13 NOVEMBER 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE	DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED			
Edward P. Fox							13 Nov. 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS			NAVAL HOSPITAL, NAVAL MEDICAL COMMAND						
E. FOX LT, MC, USNR				NATIONAL CAPITAL REGION, BETHESDA, MD 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION	CITY OR TOWN			COUNTY	STATE
Burial	11/17/86	Arl. Nat'l. Cem.			Arl. VA					
24. FUNERAL DIRECTOR NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				NOV 17 1986						

1. PHOTOGRAPH

negative

2. PRINTS
3. FILM
4. SLIDES
5. MOUNTS
6. PRINTS
7. FILM
8. SLIDES
9. MOUNTS

NO HOSPITAL OR ATTENDING PHYSICIAN. The

HOSPITAL, OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 2 4 1 4

1. DECEASED NAME (TYPE OR PRINT) FIRST Volina MIDDLE Eugene LAST Braxton			REG. NO.
			2d. DATE OF DEATH 11 27 86
3. SEX Female			4. RACE White
5. DATE OF BIRTH MONTH 2 DAY 28 YEAR 20			6. AGE (IN YEARS LAST BIRTHDAY) 66 yrs.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia			7b. CITIZEN OF WHAT COUNTRY? United States
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County
9. WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			10. CITY OR TOWN OF DEATH Derwood
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16501 Killdeer Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner
12b. KIND OF BUSINESS OR INDUSTRY Restaurant			13. STATE Florida
13c. COUNTY Orange			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. CITY OR TOWN Orlando			13e. STREET ADDRESS 203 2nd Street
14. FATHER'S NAME FIRST Claude MIDDLE Eugene LAST Davis			15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE Agnes LAST Owens
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 256-32-1014
17. INFORMANT Geri Howard,			16. ADDRESS 16501 Killdeer Drive Derwood, MD 20855
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Failure			
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic pancreatic carcinoma			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET		CITY OR TOWN	COUNTY
21g. CITY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/7/86, 19 86, to 11/21, 19 86, that (I) (we) last saw the deceased alive on 9/25, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Wayne L. Meyer		DEGREE	22c. DATE SIGNED 11/28/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne L. Meyer		22e. ADDRESS 19642 Club House Lane #615, Gaithersburg, MD 20878	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-28-86	23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory
23d. LOCATION CITY OR TOWN Alexandria, Virginia		23e. COUNTY Virginia	23f. STATE
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc. ADDRESS 1804 T Street, NW, Washington, DC 20009		25a. DATE REC'D. BY REGISTRAR DEC 1 1986	25b. REGISTRAR'S SIGNATURE Julia Dandrea

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician or attending physician be consulted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please return certificate papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18b ANY injury or other traumatic event, the medical examiner must be consulted.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 32415

REG. NO.

1 - FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
Laura S Brennan2a. DATE OF DEATH MONTH DAY YEAR
11 30 862b. HOUR
1402 M

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR
Feb. 16, 1910

6. AGE (IN YEARS LAST BIRTHDAY)

76
YRS.

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

New York

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED NEVER MARRIED WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County,
MD.

10. CITY OR TOWN OF DEATH

Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT A SURCH FACILITY, GIVE STREET ADDRESS)

Shady Grove Adventist Hospital

12a. USUAL OCCUPATION

Secretary

12b. KIND OF BUSINESS OR
INDUSTRYAmerican
Red Cross

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Bethesda

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS / ZIP CODE

9219 Laurel Oak Dr. 20817

14. FATHER'S NAME

First

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

First

MIDDLE

LAST

Rose

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
If YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

107 10 8463

17. INFORMANT

Mrs. John Flynn

ADDRESS

9219 Laurel Oak Dr.
Bethesda, MD 20817APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 weeks

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b) EXPENSIVE BILATERAL PNEUMONITIS

2 weeks.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

HEART FAILURE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES NO YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

No

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHITE NOT WHITE
AT WORK NOT AT WORK

22a. I certify that (I) (this hospital) attended the deceased from

11-15 1986 to 11-30 1986, that (I) (we) lost

soul (he deceased alive on 11-30 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

J. Ben Untiveros, MD

DEGREE

ATTENDING
PHYSICIAN DIRECTOR STAFF
PHYSICIAN 22c. DATE SIGNED
11-30-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

J. Ben Untiveros, MD

22e. ADDRESS
16220 FREDERICK RD # 427
GAITHERSBURG, MD 20887

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

Dec. 2, 1986

23c. NAME OF CEMETERY OR CREMATORIUM

Riverview Cemetery

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES

PA, NAME ADDRESS 300 West Montgomery Ave. Rockville MD 20850

25a. DATE REC'D. BY REGISTRAR

11-03-1986

25b. REGISTRAR'S SIGNATURE

Julie Johnson-Kendall

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be carbon copied. Please remember to file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event,

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32416					
										REG. NO.					
1 - STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
	HERBERT S Bright						11 28 86			7a m					
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male.	Caucasian			Sept. 13, 1919			67			MONTHS	DAYS	HOURS	MIN.		
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION				12b. KIND OF BUSINESS OR TRADE	
New York	United States			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County			Math. / Physicist				Computing	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12c. USUAL OCCUPATION				
BETHESDA	Suburban										12d. KIND OF BUSINESS OR TRADE				
13a. STATE	13b. COUNTY	13c. CITY, OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			12e. STREET ADDRESS / ZIP CODE						
Maryland	Montgomery	Bethesda	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7840 Aberdeen Road/20814			7840 Aberdeen Road/20814						
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ADDRESS					
I.			Bright	Dorothy					Rosen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No	122-01-9946			Lee Ella May-Bright, same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
aspiration pneumonia															
DUE TO, OR AS A CONSEQUENCE OF (b)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Sarcoidosis, Nocardiosis															
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (the hospital attended the deceased from 10/14, 19 86, to 11/28, 19 86, that (I) did not see the deceased alive on 11/28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.)															
22b. SIGNATURE Alan Chanale										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/28/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Chanale										22e. ADDRESS 15225 SHADY GROVE RD ROCKVILLE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec. 5, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery		23d. LOCATION CITY OR TOWN Beeville, Texas		CITY OR TOWN		COUNTY		STATE			
Burial															
24. FUNERAL DIRECTOR NAME		Robert A. Pumphrey Funeral Homes ADDRESS 7557 Wisconsin Ave. Bethesda, MD 20814 PA		25a. DATE REC'D. BY REGISTRAR DEC 2 1986		25b. REGISTRAR'S SIGNATURE Maria Sanderson-Lindner									

80-4-311 PL850

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-tranit permit. Then place it above carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 32417

FOR
STATE
REGISTRAR

25077 NOV

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JULIA	MIDDLE MARY	LAST BRODERICK	2d. DATE OF DEATH Nov 16 1986	MONTH NOV	DAY 16	YEAR 1986	2d. HOUR 11:40A.M.
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 2, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 yrs.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE COUNTRY Wash., DC			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY		IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CARRIAGE HILL BETHESDA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY USGov't.	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12301 Coppola Drive 20854	
14. FATHER'S NAME FIRST Patrick Joseph Broderick			LAST		15. MOTHER'S MAIDEN NAME Nora (Unavailable) Hunt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 364-07-7276		17. INFORMANT Rosemary Manfreda, niece, 12301 Coppola Dr.		ADDRESS Potomac, Md. 20854			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			DUE TO, OR AS A CONSEQUENCE OF (b)		Chronic Obstructive Respiring Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Ileostomy										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED <small>AT HOME</small> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from April 19, 1984, to patient, 19, 19, that (I) (we) last saw the deceased alive on Nov 15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Helen J. [Signature]		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov 16 1986				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold I. Passes MD		22e. ADDRESS 3701 Mass Ave Wash DC 20016								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 19, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN Silver Spring, Mont. Maryland		25a. DATE REC'D. BY REGISTRAR NOV 21 1986		
24. FUNERAL DIRECTOR NAME De Vol FH		ADDRESS WILSONS INN, NW, DC.				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove sticker from page 2 and send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "Yes" above any injury, or other traumatic event, the medical examiner must be called to make a post-mortem examination.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 32 8

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR																
MAY I BROOKS						11	5	86	8:33 A.M.																	
3. SEX			RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.														
Female			Black	MONTH	DAY	YEAR	70																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH															
Md.			USA		<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	MONTGOMERY MD.				Silver Spring														
					<input type="checkbox"/>	WIDOWED	<input checked="" type="checkbox"/>																			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				13a. STATE															
Holy Cross Hospital			13b. CITY OR TOWN								Md.															
13c. COUNTRY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE				13f. ZIP CODE															
							1363 Smith Village Rd 20904																			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
David Jackson			Louise Matthews				16c. SOCIAL SECURITY NO. 215-38-3529				Patrick Brooks (husband)				Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonitis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>metastatic Ca lung</i>				6 mo											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(c)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>11-5-1986</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.				22b. DATE SIGNED 11-5-86											
22c. DEGREE <i>Dengstach M.D.</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-8-86		23c. NAME OF CEMETERY OR CREMATORIUM Good Hope Cemetery		23d. LOCATION CITY OR TOWN SilverSpring, Montg. MD COUNTY STATE				23a. DATE REC'D. BY REGISTRAR NOV 13 1986															
24. FUNERAL DIRECTOR NAME George R. Snowden			24b. ADDRESS 246 N. Washington Dr., Rockville, MD 20851		25a. REGISTRAR'S SIGNATURE <i>John L. Johnson</i>																					

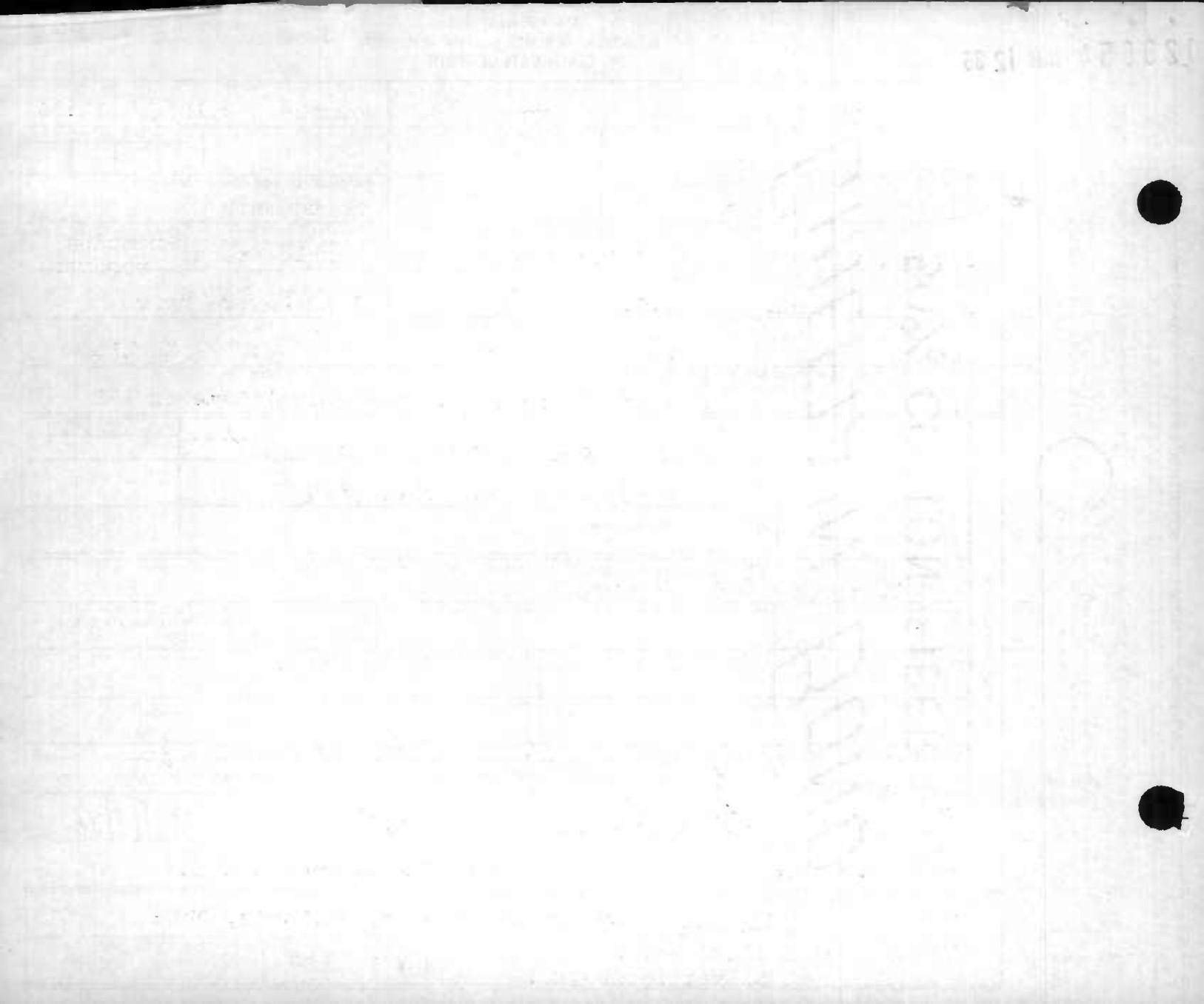
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-cremation permit. Then please return pages 1 and 2 (which should be filed within 24 hours after death) with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked **NO**, show injury or other condition present the medical examiner must initial next to item 21.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 3 2 1 4					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Charles Amos Brown								November		8, 1986			12:35A		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		MONTH 9 DAY 10 YEAR 08			78		MONTHS YRS.		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.						
Ohio		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR Pressman	
Silver Spring		Colonial Villa Nursing Home										Merkle Press		20903	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		1212 Devere Drive				
14. FATHER'S NAME FIRST			MIDDLE	LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Emmett				Brown			Oda			B.	Zerkle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
N/A			277 05 0352			Anne J. Brown (Wife)			Same as 13E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												<i>Cardiopulmonary arrest</i>			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular Accident</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Alzheimer's Disease</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 6, 1986, to Nov. 8, 1986, that (I) (we) last saw the deceased alive on Nov. 6, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I further certify that (I) (we) did not view the body after death.												22b. DATE SIGNED 11/8/86			
22c. MEDICAL CERTIFICATION ATTENDING PHYSICIAN		22d. DEGREE			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
Charles Benner					22e. ADDRESS 8580 2nd Avenue S.S. Md.										
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 11/11/86			23c. NAME OF CEMETERY OR CREMATORIUM Evergreen Cemetery			23d. LOCATION CITY OR TOWN St. Paris, Ohio COUNTY							
24. FUNERAL DIRECTOR Hines/Rinaldi		ADDRESS 11800 New Hamp. Ave; Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR NOV 10 1986							
25b. REGISTRAR'S SIGNATURE John Charles Kendall															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please file this certificate with the State Dept. of Health and Mental Hygiene private to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR <u>noon</u>		
<i>Gertrude L. Brown</i>						<u>11</u>	<u>17</u>	<u>86</u>		<u>1245</u> M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
<input checked="" type="checkbox"/> Female		<input checked="" type="checkbox"/> Black		MONTH	DAY	YEAR	<u>74</u>	YEARS	MONTHS	DAYS	HOURS	MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
<u>D.C.</u>		<u>U.S.A.</u>				<u>Montgomery</u>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
<u>Takoma Park</u>		<u>Washington Adventist Hosp.</u>						<u>Sorter-Bergman's Laundry</u>				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
<u>Md.</u>		<u>P.G.</u>		<u>Cap. Hgts.</u>		YES <input checked="" type="checkbox"/>		<u>600 Jadeleaf Ave.</u>				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
<u>(Unknown)</u>				<u>Williams</u>		<u>Ella</u>				<u>Queen</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		<u>579-16-0049</u>		A Ellsworth Crutchfield-Greenbelt, Md.		<u>8405 Greenbelt Rd.,</u>		<u>1 MONTH</u>				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>NON SMALL CELL CARCINOMA OF RIGHT LUNG</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) <u>(Physician)</u> attended the deceased from <u>OCTOBER 17, 1986</u> , to <u>NOVEMBER 17, 1986</u> , that (we) lost saw the deceased alive on <u>NOVEMBER 16, 1986</u> , and that in (my) <u>(me)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> did not view the body after death.												
22b. SIGNATURE <u>James A. Brown, MD</u> DEGREE												
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>11/17/86</u>										
22e. ADDRESS <u>14800 PHYSICIANS LANE</u> <u>ROCKVILLE MD 20810</u>												
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>11/21/86</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>LINCOLN MEM. CEM.</u>		23d. LOCATION CITY OR TOWN <u>SUITLAND</u> , COUNTY <u>P.G.</u> , STATE <u>MD.</u>						
24. FUNERAL DIRECTOR NAME <u>H. S. WASHINGTON & SONS</u> ADDRESS <u>4925 BURroughs Ave. N.E.</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 19 1986</u>		25b. REGISTRAR'S SIGNATURE <u>John Wilson-Parker</u>						



025858 DEC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 86 32421						
1. DECEASED NAME (TYPE OR PRINT)		FIRST SALLY	MIDDLE BROWN	LAST	2a. DATE OF DEATH 11-25-86	MONTH	DAY	YEAR	2b. HOUR 1:20 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 27 YEAR 10	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady (Ret.)						12b. KIND OF BUSINESS OR INDUSTRY Unobtainable	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6121 Montrose Road (20852)			
14. FATHER'S NAME FIRST Henry		MIDDLE	LAST Brown	15. MOTHER'S MAIDEN NAME FIRST Annie						MIDDLE	LAST Stone
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-86-3230		17. INFORMANT Hebrew Home-Social Worker						ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest.</u>											
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>Tonsil amyothria</u>											
DOUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVS</u> years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) this hospital attended the deceased from <u>8-4-86</u> to <u>11-25-86</u> , that (I) (we) last saw the deceased alive on <u>11-25-86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>LORETO S. ALBIOF, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/25/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LORETO S. ALBIOF</u>		22e. ADDRESS <u>6121 MONTRSE Rd.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/28/86		23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Gdn.; Falls Church; Fairfax; Va.		23d. LOCATION CITY OR TOWN					
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHPLS. ADDRESS 1170 Rockville Pike; Rockville, Md. 20852				TICK DATE REC'D. BY REGISTRAR DEC 01 1986		25b. REGISTRAR'S SIGNATURE <u>Julie Danzansky</u>					

032600-52

Wetland

P-47

25

01 26 11

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K2 N

Gulf Coast

The well was never opened
without water being

present except when

the pump was turned

on.

Water was present in

the well when it was

first drilled.

Water was present in

the well when it was

30

24240 NOV 18 1986

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use in the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

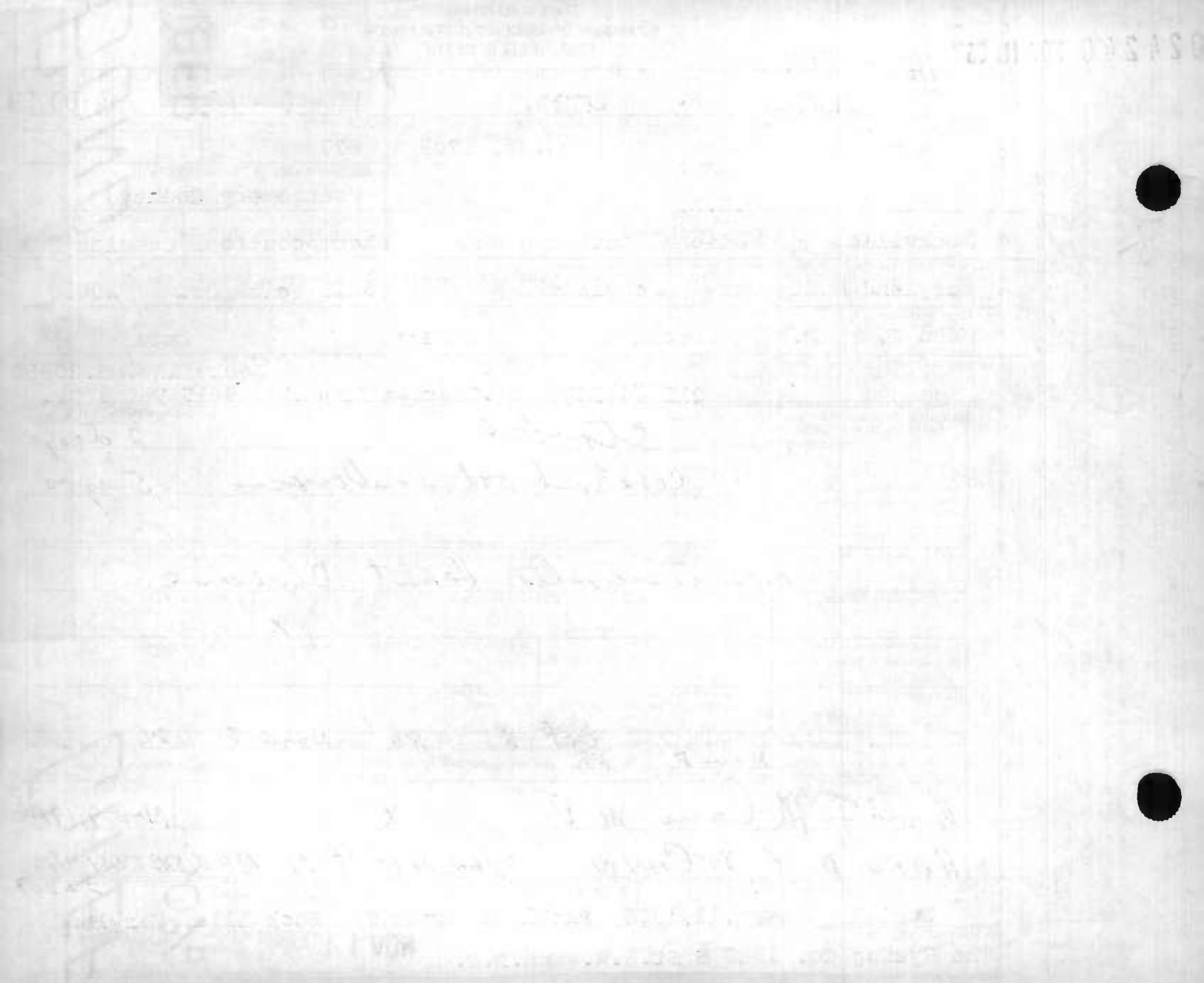
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 32 22

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Charles F. Bruening						11 - 8 - 86				4:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
male		white		Feb. 26, 1909		77			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Maryland		U.S.A.				Montgomery County			MONTHS HOURS MIN.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Rockville		National Lutheran Home		pharmaceutical			Chemist FDA				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9815 Veirs Dr. 20850		
14. FATHER'S NAME John		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Nellie			16. ADDRESS Rockville, Md. 20850				
F.											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-44-5638		17. INFORMANT Mrs. Theresa Bruening			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>stroke</u> DUE TO, OR AS CONSEQUENCE OF (b) <u>Cerebral atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>5 yrs.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>arteriosclerotic heart disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None P		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Oct. 8, 1986, to Nov. 8, 1986, that (I) (we) lost saw the deceased alive on Nov. 8, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harold F. McConn, M.D.						DEGREE	22c. DATE SIGNED Nov. 9, 1986				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F. McCONN		22e. ADDRESS 4362-26th St. N. ARLINGTON, VA									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 11, 1986		23c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		23d. LOCATION CITY OR TOWN Rockville, Maryland		23e. COUNTY 22207			
24. FUNERAL DIRECTOR The Hysong Co. 1300 N St. N.W. Wash. D.C.		ADDRESS NOV 14 1986		25a. DATE REC'D. BY REGISTRAR NOV 14 1986		25b. REGISTRAR'S SIGNATURE Julia D. Danner					

2017.0054.00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the attending physician and completed by the funeral director, physician or coroner.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, physician or coroner, it should be detached so as not to bind the burial permit. Then please remove carbon paper. Please retain this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified at once.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						3 6 3 2 4 2 5				
2a. DECEASED NAME (TYPE OR PRINT)				FIRST DEBRA	MIDDLE JO	LAST BRUNK	2b. DATE OF DEATH NOVEMBER 17, 1986				MONTH NOVEMBER	DAY 17	YEAR 1986	2b. HOUR 12:35 a.m.
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH FEBRUARY DAY 29 YEAR 1968		6. AGE (IN YEARS LAST BIRTHDAY) 18 yrs				IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 0		
7a. BIRTHPLACE COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.								
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER (NIH)		12a. USUAL OCCUPATION (TYPE OR WORD OR PHRASE OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY High School						
13. STATE VIRGINIA		14. COUNTY Rockingham		13c. CITY OR TOWN DAYTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. #3, Box 94 22821						
14. FATHER'S NAME FIRST Merle		MIDDLE Brunk	LAST	15. MOTHER'S MAIDEN NAME Theda				16. ADDRESS Ruppert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 227-98-6809		17. INFORMANT MR. MERLE BRUNK (FATHER)				18. SAME AS ABOVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGIC PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF (b) Hodgkin's Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF Years Days-weeks														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 22, 86 , to NOV. 17, 1986 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOV. 17, 1986 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> NOT <input type="checkbox"/> view the body after death.														
22b. SIGNATURE <i>Peter Q. Eichacker</i>		22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Peter Q. EICHACKER</i>		22e. NATIONAL INSTITUTES OF HEALTH BETHESDA, MD 20892				22f. DATE SIGNED 11/17/86								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 20, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Weaver's Mennonite		23d. LOCATION CITY OR TOWN Harrisonburg, Virginia								
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOME NAME P.A., 7557 Wisc. Ave. Bethesda, Maryland														
25a. DATE REC'D. BY REGISTRAR NOV 21 1986														
25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Randall</i>														

2025 RELEASE UNDER E.O. 14176

023651 NOV 2 8 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trouble, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 3 2 4 2 1							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Helen Buchanan						11/6/86					9:35 P M						
3. SEX			4. RACE	B2	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	IF UNDER 24 HRS				
F					4/19/1895				91			YEARS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD					
WASHINGTON D.C.			U.S.A.						Montgomery Co.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda			Suburban Hospital			NONE			NONE								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE			
13a. STATE MD			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			5121 GROSVNOR LANE				20814				
14. FATHER'S NAME FIRST THEODORE			MIDDLE	LAST	HERBERT	15. MOTHER'S MAIDEN NAME FIRST ADDIE			MIDDLE	LAST	GOODLOE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO N/A			17. INFORMANT			ADDRESS								
			578-05-9529			GERALDINE WARFIELD			3303 20TH ST N.E. WASH D								
18. CAUSE OF DEATH (Enter only one cause per line for a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Bleeding</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Aspiration pneumonia</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
—																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —			21f. LOCATION STREET —			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>11-6-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			11-2-1986			to <u>11-6-1986</u>											
22b. SIGNATURE <u>Mangal Kathleen M.P.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/7/86</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MANGAL KATIKINENI</u>			22e. ADDRESS 3301 NEW MEXICO AVE NW D.C. 20016														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>11-14-86</u>			23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL			23d. LOCATION CITY OR TOWN ARLINGTON			COUNTY	STATE				
BURIAL												ARL.	VA				
24. FUNERAL DIRECTOR NAME JOHNSON & JENKINS F.H.			ADDRESS 716 KENNEDY ST N.W.			25a. DATE REC'D. BY REGISTRAR NOV 10 1986			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>								

MS. A. 1.6.288

18-12-11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM #4. MAIL OR FAX TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 4. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 21201 PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 32425								
1- FOR STATE REGISTRAR			Deceased Name FIRST George MIDDLE G. LAST Burdette									2a. DATE KNOWN OF EST. DEATH MATED								
CEASED NAME (TYPE OR PRINT) Perry												MONTH DAY YEAR								
SEX Male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				
						1 16 15 71						MONTHS		DAYS		HOURS		MONTH DAY YEAR		
																		2d HOUR		
																		MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? American			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery								
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder-Realtor								
13a. STATE Maryland			13b. COUNTY Montg.			13c. CITY OR TOWN Damascus			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 9124 Gue Road 20872								
14. FATHER'S NAME FIRST John MIDDLE J. LAST Burdette			15. MOTHER'S MAIDEN NAME FIRST Cora MIDDLE I. LAST King																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-16-0195			17. INFORMANT Betty S. Burdette														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) coronary arteriosclerosis																				
(c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE John Tander			TITLE (SPECIFY) M.D. DeGupta									MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT) John Tander			ADDRESS 8218 WISCONSIN ave									DATE SIGNED 11-14-86								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/17/86			23c. NAME OF CEMETERY OR CREMATORIAL Damascus Cemetery			23d. LOCATION CITY OR TOWN Damascus			COUNTY Montg.			STATE Md.					
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.												25a. DATE REC'D. BY REGISTRAR NOV 17 1986			25b. REGISTRAR'S SIGNATURE Jim Egan, Jr.					
DHMH - 17 (VR A15 ME (5))																				

EXPLANATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 .32420		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
DAVID			WILLIAM	BURKE Jr.	November 1, 1986						A	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		Caucasian	MONTH DAY YEAR JANUARY 29, 1929			57			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.		United States						MONTGOMERY COUNTY				MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK AND WHETHER PART-TIME OR FULL-TIME)			12b. KIND OF BUSINESS OR INDUSTRY				
BETHESDA		NIH, THE CLINICAL CENTER			Structural Engineer			Consulting				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND		MONTGOMERY		BETHESDA					9512 LINDALE DR. 20817			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
		David	W.	Burke				Ida	Elizabeth		not available	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
Yes		Korean			578-36-4953			MRS. BONITA BURKE (SAME AS PT.) WIFE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Sepsis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) Pyelonephritis												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (c) Ureteral stenosis as result of adeno carcinoma												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 21, 1986, to November 1, 1986, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 27, 1986, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892			11/11/86				
Robert Cameron M.D.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Nov. 4, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery			23d. LOCATION CITY/TOWN Silver Spring COUNTY Maryland					
Burial												
24. FUNERAL DIRECTOR NAME		Robert A. Pumphrey Funeral Homes, P.A. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
					NOV 6 1986							
7557 Wisconsin Ave. Bethesda, Maryland 20814												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial/memorial service. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0010111850

024527 NOV

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

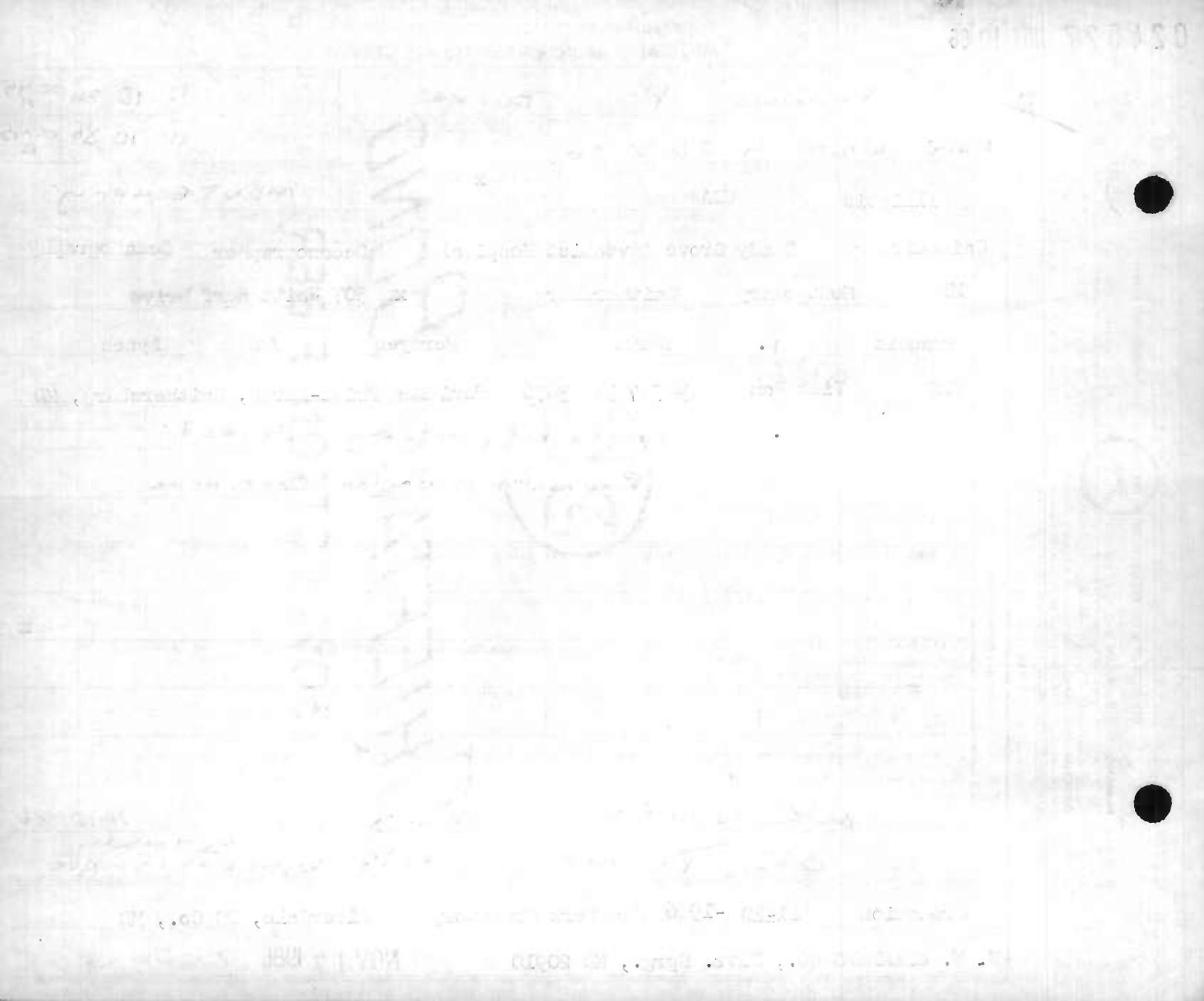
REG. NO.

32421

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, BALTIMORE, MARYLAND. PAGES 1, 2, AND 3 ARE TO BE KEPT ON HAND, WITH FORM PM-3 RETAIN PAGES 1 AND 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b HOUR AM	
<i>Francis P. Burke</i>						<input checked="" type="checkbox"/>	11	10	86	00 45	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN						
Male	White	4 23 30	56 RS.								
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10d. DATE PRONOUNCED DEAD MONTH DAY YEAR	
Illinois		USA					Montgomery			11 10 86 0045 PM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Gaithersburg		Shady Grove Adventist Hospital			Oceanographer		Oceanography				
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 507 White Surf Drive		20760	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Francis		P.		Burke		Bernyce		Ann		Lynch	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		(IF YES, GIVE WAR OR DATES) Viet Nam		16b. SOCIAL SECURITY NO. 347 24 3676		17. INFORMANT Teri Lea Price-Burke, Gaithersburg, MD		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory arrest.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Broncho alveolar carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John Tamber</i>		TITLE (SPECIFY) M.D. <i>Douglas</i>		MEDICAL EXAMINER		DATE SIGNED <i>11-10-86</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>John Tamber</i>		ADDRESS <i>8288 Bethesda</i>		<i>Wisconsin Ave</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-11-1986		23c. NAME OF CEMETERY OR CREMATORIAL Chambers Crematory		23d. LOCATION CITY OR TOWN Riverdale, PG Co., MD		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO., Slvr. Sprg., MD 20910		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 17 1986		25b. REGISTRAR'S SIGNATURE <i>John Tamber</i>					
07/84 25M		BP									
DHMH - 17 (VR A15 ME (5))											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from use as the burial-trust permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32428				
REG. NO.														
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)			MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		RETA			D.		BURNS		11 13 86					8:00 PM
1c. SEX		4 RACE			White		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		Cauc.					MONTH DAY YEAR		89		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			UNITED STATES		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.			
Illinois									Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			BROOKE GROVE Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
OLNEY							Homemaker							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		20872				
Maryland		Montg.		Damascus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24712 Tandem Drive						
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME						
		(unknown)				Dayhoff		Jenny						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. IF YES, GIVE WAR OR DATES		16c. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		577-84-1940		George W. Burns		Item 13								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cachexia														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET TH		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9-3-80, 19 80, to 11-13 19 86, that (I) (we) last saw the deceased alive on 11-9 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not (did) not view the body after death.														
22b. SIGNATURE TED E. Howe. MD		22c. DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR	STAFF PHYSICIAN	22d. DATE SIGNED 11-13-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TED E. Howe. MD					22e. ADDRESS OLNEY, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/17/86		23c. NAME OF CEMETERY OR CREMATORIAL Damascus Cemetery		23d. LOCATION CITY OR TOWN Damascus		COUNTY	STATE					
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 17 1986		25b. REGISTRAR'S SIGNATURE Richard Pendleton								
BP _____														
DHMH - 16 60M 7/84 (VRA 15, 4)														

025518 DEC 1 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon paper and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.
1 - STATE REGISTRAR		1 DECEASED NAME MARY FIRST BERTHA MINTER BURRUSS LAST (TYPE OR PRINT) <i>Bertha</i>			20 DATE OF DEATH MONTH YEAR Nov. 19, 1986 Nov. 19 1986
3 SEX Female		4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1889	6 AGE (IN YEARS LAST BIRTHDAY) 97 yrs	2b HOUR 5:10 PM 5:10 M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5009 McCall Street 20853
14. FATHER'S NAME FIRST MIDDLE LAST Randolph Tucker Minter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Frances Cockerille			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-66-2636-11	17 INFORMANT Mrs. Frances Axline	ADDRESS 5009 McCall Street Rockville, MD 20853	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>10 yrs.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 11/19 81 to 11/19 86			
21d. INJURY OCCURRED <small>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NEUT WHILE <input type="checkbox"/> ALL WORK</small>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 11/19	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (s) he (she) attended the deceased from 11/19 81 to 11/19 86, that (s) (we) last saw the deceased alive on 11/19 86, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If you did not see the body after death, check here.)					
22b. SIGNATURE <i>Marvin Waller M.D.</i>		22c. DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 11/19/86	
22e. ADDRESS 8218 W 15th Av. Beth. Md. 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 21, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Warrenton Cemetery	23d. LOCATION CITY OR TOWN Warrenton, Fauquier Co., VA		
24. FUNERAL DIRECTOR NAME Moser Funeral Home, Inc. Warrenton, VA 22186	25a. DATE REC'D. BY REGISTRAR NOV 25 1986	25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>			
DHMH - 16 60M 7/84 (VRA 15, 4)					

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AND RETURNING
THEIR OWN PROPERTY
AND PERSONAL PROPERTY
TO THE GOVERNMENT

DETAINED
RELEASING
AND RETURNING
THEIR OWN PROPERTY
AND PERSONAL PROPERTY
TO THE GOVERNMENT

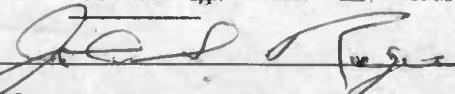
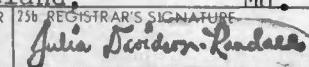
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AND RETURNING
THEIR OWN PROPERTY
AND PERSONAL PROPERTY
TO THE GOVERNMENT

DETAINED
RELEASING
AND RETURNING
THEIR OWN PROPERTY
AND PERSONAL PROPERTY
TO THE GOVERNMENT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGE 5 SHOULD BE USED AS A BURIAL RECORD. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL RECORD. PAGE 4 SHOULD BE USED AS A Cremation Record. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR BURIAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Mamie	MIDDLE E.	LAST Butler	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH 11	DAY 16	YEAR 86	2b. HOUR M	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 20, 1893	6. AGE (IN YEARS LAST BIRTHDAY) 93 yrs.	7. IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD 11/16 1986	MONTH 11	DAY 16	YEAR 86	2d. HOUR P. M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13808 Bonsel Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 13808 Bonsel Lane		20906				
14. FATHER'S NAME FIRST Henry		MIDDLE	LAST Lewis	15. MOTHER'S MAIDEN NAME FIRST Sarah		MIDDLE	LAST Harris				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO		16b. SOCIAL SECURITY NO. 225-50-9464		17. INFORMANT Ms. Sarah Frances Watts Henry/daughter		ADDRESS same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER 1919 Seminary Road									
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery County, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-21-86		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial		23d. LOCATION CITY OR TOWN Suitland		23e. COUNTY Md.			
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St. N.E., D.C.		25a. DATE REC'D. BY REGISTRAR NOV 24 1986		25b. REGISTRAR'S SIGNATURE 							



052511 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

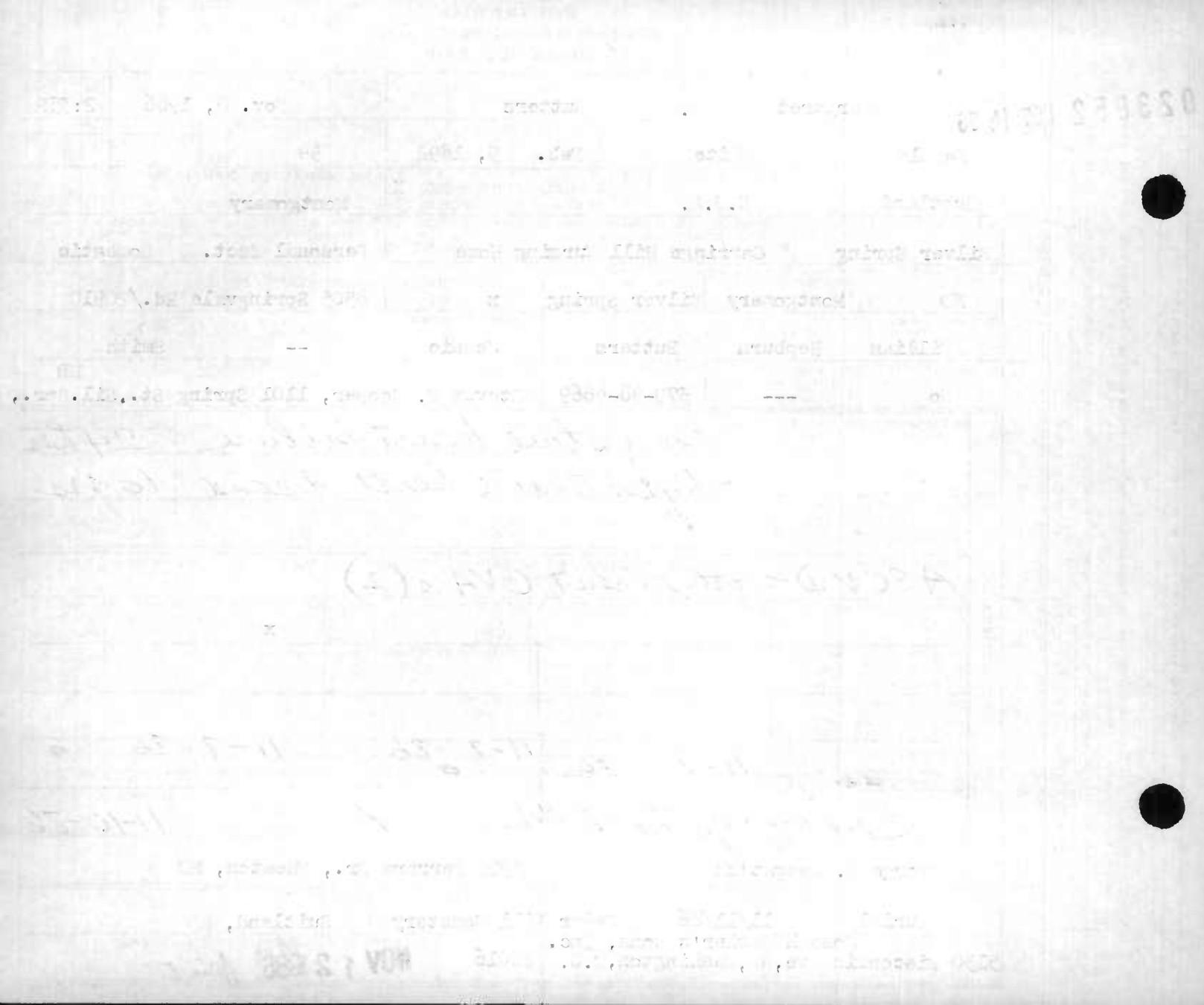
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 6 3 2 4 3				
					REG. NO.				
1 - FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
1. DECEASED NAME (TYPE OF PRINT)	Margaret	S.	Butters	Nov. 8, 1986				2:35 P.M.	
2. SEX	Female	4. RACE	White	5. DATE OF BIRTH	MONTH	DAY	YEAR		
				Feb.	5,	1892			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Scotland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
94 YRS						Montgomery	MD.		
10. CITY OR TOWN OF DEATH	Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
		Carriage Hill Nursing Home			Personal Sect.			Domestic	
13a. STATE	MD	13b. COUNTY	Montgomery	13c. CITY OR TOWN	Silver Spring	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
								8505 Springvale Rd./20910	
14. FATHER'S NAME	FIRST William	MIDDLE Hepburn	LAST Butters	15. MOTHER'S MAIDEN NAME	FIRST Jessie	MIDDLE —	LAST Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	16b. SOCIAL SECURITY NO.	579-48-4669	17. INFORMANT	ADDRESS			MD	
				Steven M. Cooper, 1101 Spring St., Sil. Spr.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	congestive heart failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	hypertensive heart disease							24 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								10 yrs	
(b)									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
ASCV D with recent CVA's (2)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) <input type="checkbox"/> (did not) view the body after death.	11-7 1986	to	11-8 1986						
22b. SIGNATURE <i>George F. Sengstack</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OF PRINT)	ADDRESS			11-10-86					
George F. Sengstack	3929 Ferrara Dr., Wheaton, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	COUNTY	STATE				
Burial	11/11/86	Cedar Hill Cemetery	Suitland, MD						
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE							
	NOV 12 1986	<i>Julia D. [Signature]</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 23 is any injury, or other traumatic event, the medical examiner should be notified.

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 324 32

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.
William Ross Cameron						
2. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			20. DATE OF DEATH MONTH DAY YEAR	2b HOUR
Male	Caucasian	April 25, 1896			11 6 86	11:20 AM
6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.				
90						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	
Canada	United States				Montgomery County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Bethesda	Suburban Hospital			Physician		
12b. KIND OF BUSINESS OR INDUSTRY	Medical/Health					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						20852
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6060 California Circle #102
14. FATHER'S NAME FIRST Hugh	MIDDLE W.	LAST Cameron	15. MOTHER'S MAIDEN NAME FIRST Mina			MIDDLE LAST Crawford
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Yes Korea	16c. ADDRESS 10237 Holly Hill Place Dr. Ronald R. Cameron Potomac, Maryland 20854	17. INFORMANT (Son)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>developed arteriosclerosis</i>						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, to _____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 11-6-86
22b. SIGNATURE <i>D.L. Bucky</i>						22d. DEGREE MD
22e. ADDRESS 809 Veirs Mill Rd Rockville						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE November 8, 1986	23c. NAME OF CEMETERY OR CREMATORIUM Metropolitan Crematory	23d. LOCATION CITY OR TOWN Alexandria	COUNTY	STATE Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, ADDRESS P.A. 300 West Montgomery Ave., Rockville, MD	25a. DATE REC'D. BY REGISTRAR NOV 12 1986	25b. REGISTRAR'S SIGNATURE <i>Jane DeLoach Randolph</i>				

0530



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8 6 3 2 4 3 3
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11/29 1986 M
John			M.			Campbell						2b HOUR 24 HOUR 8:16
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.					2c. DATE PRONOUNCED DEAD 11/29 1986 A.M.	
Male	White	Dec. 2, 1901	84 yrs	MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
Penn.		USA								Highway Inspector County, Md.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9601 Dilston Road		12a. PLACE OF OPERATION FOR MOST OF WORKING LIFE		12b. BUSINESS OR INDUSTRY						
Maryland		Montgomery		Silver Spring				9601 Dilston Road 20903				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST	
Patrick				Campbell		Catherine					Murphy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
N/A		170 18 9603		Carrie Campbell (Wife)		Same as 13E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												
(b)												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION STREET		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21g. LOCATION CITY OR TOWN		21h. LOCATION COUNTY		21i. LOCATION STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		TITLE (SPECIFY) John S. Rogers, M.D. Deputy M.D. MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT)										
1919 Seminary Road Silver Spring, Montgomery County, MD												
23a. BURIAL/CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12/1/86		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION CITY OR TOWN S.S.		23e. COUNTY Mont. Md.		23f. STATE Md.		
24. FUNERAL DIRECTOR NAME Kimes/Rinaldi		ADDRESS 11800 New Hamp.Ave. S.S.Md.		25a. DATE REC'D. BY REGISTRAR DEC 1 1986		25b. REGISTRAR'S SIGNATURE John S. Rogers, M.D.						

0000001630



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial-transit permit. Then please remain with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other transit. If Item 21 is marked "X" show any injury, or other transaction.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32 134	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ROBERTO			A.	CAMPOS		11-5-86				2231 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		Nov.	17	1901	84	YRS	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Chile		Chile				MONTGOMERY CO.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK AND % OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		SUBURBAN HOSPITAL		Naval Officer		Chilean Navy					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Bethesda		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4949 Battery Lane #305/20814			
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Pedro				Campos	Cupertina				Duran		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		12104 Devilwood Drive Potomac, Maryland 20854					
No		577-72-4234		Gloria M. Rohrer							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Vascular Disease</u> 26 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> 10 yrs 30 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>arterosclerotic heart disease and peripheral vascular disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1970, 19, to 1986, 19, that (I) (we) last saw the deceased alive on 1986, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
Jeremy V. Cooke		no				1986					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Jeremy V. Cooke		10400 Conn. Ave. Kensington									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Nov. 8, 1986		Gate of Heaven Cem.		Silver Spring Maryland					
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P. NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
A. 7557 Wisconsin Avenue Bethesda, Maryland				NOV 10 1986		Maria Division-Pandrea					



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T-206
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

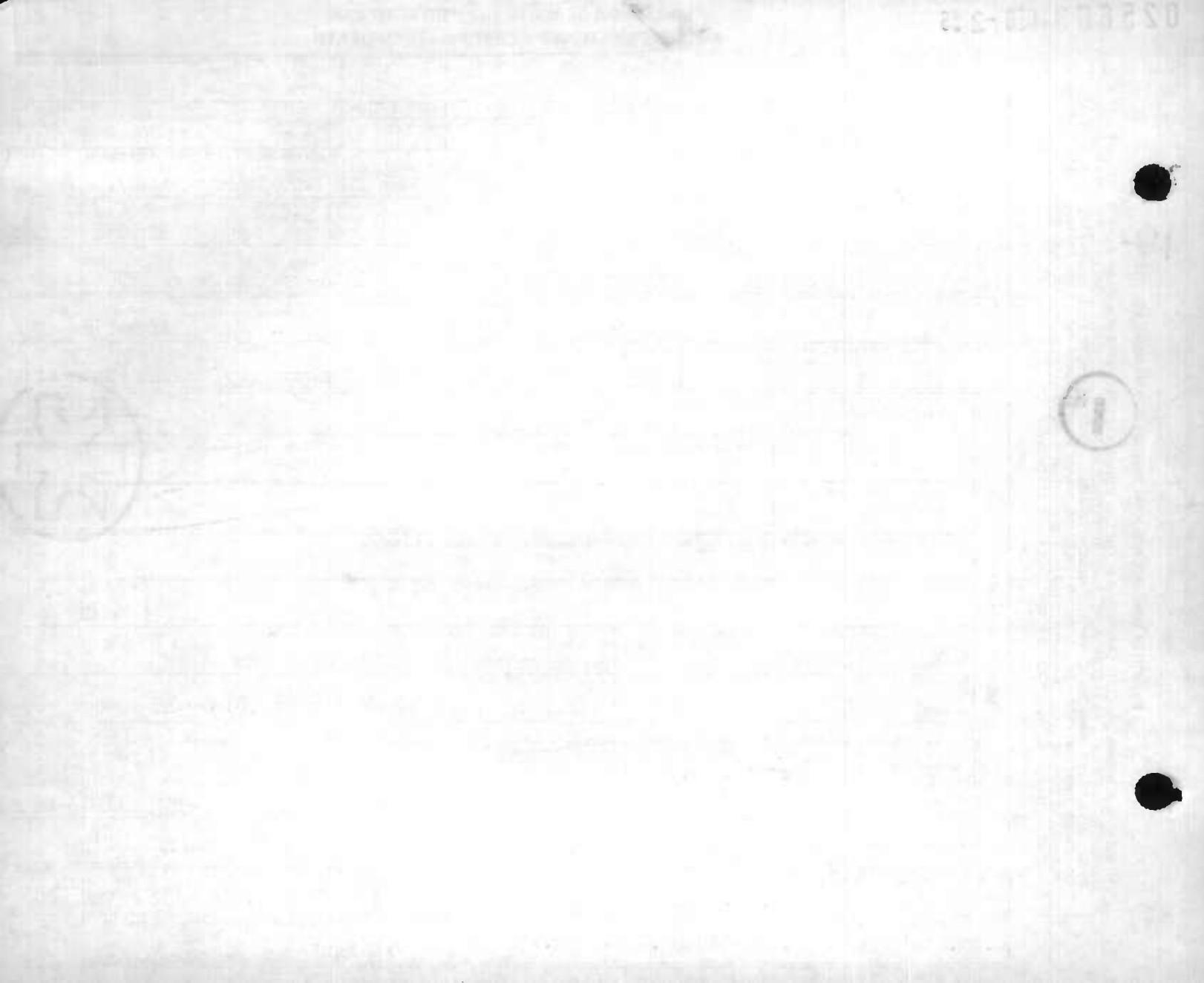
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACES PROVIDED. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AND TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM. AFTER DEATH, WITHIN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND 21201 PAY ATTENTION TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH DAY YEAR	2b. HOUR		
Manjusri			-	Chakravorty		<input checked="" type="checkbox"/>				11-15 1986	M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS MONTH DAY YEAR LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD			
Female	East Indian	May 15, 1950	36 yrs.							MONTH	DAY	YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Calcutta, India		India			WIDOWED		<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	Montgomery County,			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Rt. 108 & Headwater DRive				Teacher				Private School			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>		1324-Gresham Road 20904			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
Bipul		Ial		Banerjee	Rama				Mukherjee				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		#13					
No		579-90-3400		Kamanashish Chakravorty (Husband)		Same as							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Multiple Injuries												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
8/20 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
						<input checked="" type="checkbox"/>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road		21f. LOCATION STREET Rt. 108 & Headwater Dr., Olney, Montgomery Co.									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Md.											
ACTUAL SIGNATURE		TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER								DATE SIGNED 11-16-86			
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN Washington, District of Columbia		25a. DATE REC'D. BY REGISTRAR Nov. 25 1986				25b. REGISTRAR'S SIGNATURE <i>Juliann Deidra Pendleton</i>	
24. FUNERAL DIRECTOR J.Wm. Lee's Sons Co.		ADDRESS 300-4th St., NE, Wash., DC 20002											
BP													
DHMH - 17 (VR A15 ME (5))													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be

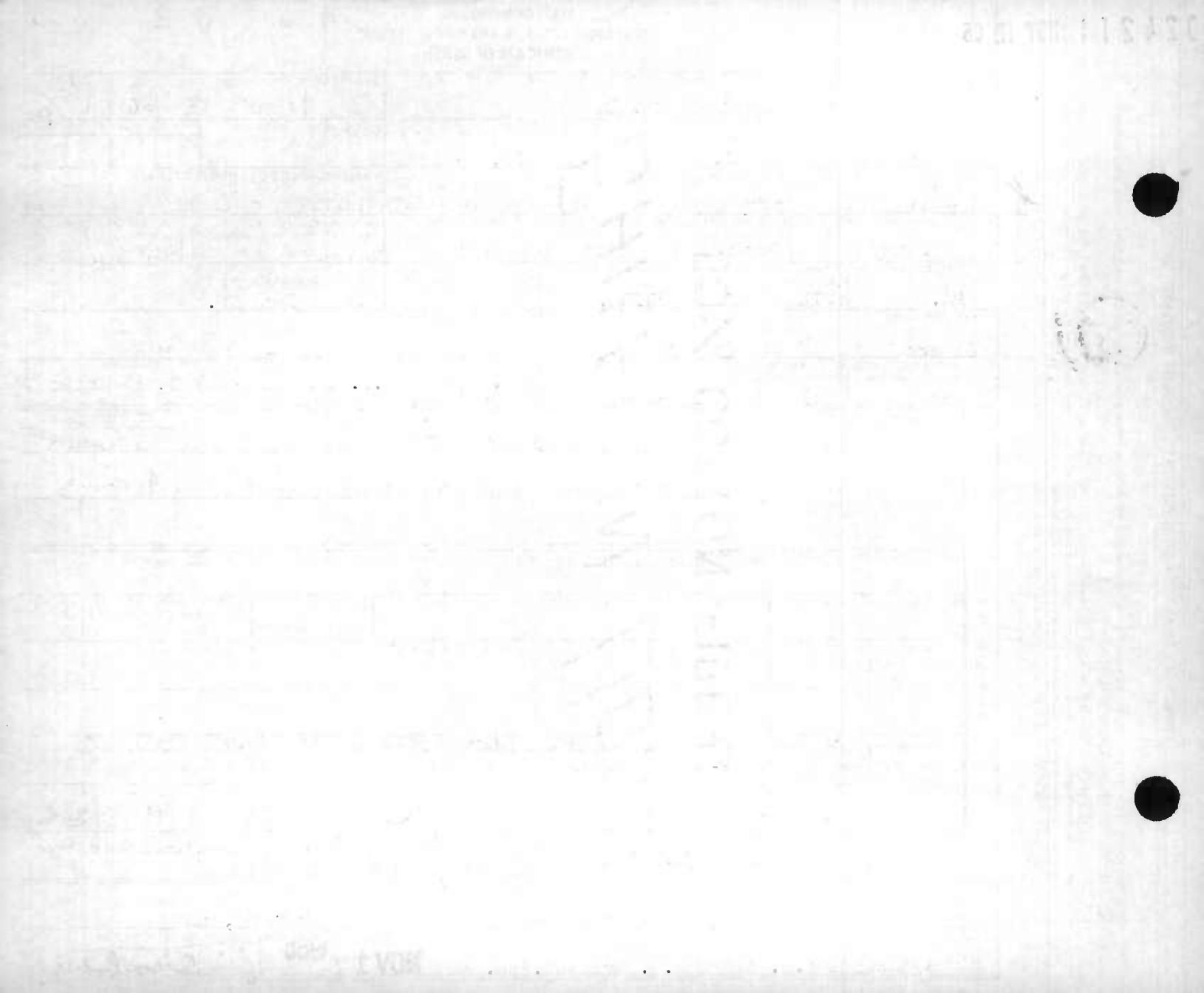
filled in by the funeral director; page 3 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the hospital or attending physician, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	32	4	50				
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR				
Mary Elizabeth Chapin						Nov 15 '86							115 PM				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			BLACK		MARCH 10, 1892			94 YRS				MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.					
PENNSYLVANIA			UNITED STATES		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Olney			Montgomery General Hospital		Housewife			Own Home									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE					
PA.			PHILADELPHIA		PHILA.			435 N 53rd ST.				99999					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST								
Albert			-	Finley	Georgiana			-	Minus								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Mr. Arthur A. F. Chapin (son) 14215 Artic Ave			ADDRESS									
No			n/a	716-16-6538		Rockville, MD 20853											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Cardiac Arrest 5 hours							
(b) Uremia & Hyperkalemia Due to, or as a consequence of										4 days							
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 15 Nov 1986 to 15 Nov 1986, that (we) last saw the deceased alive on 15 Nov 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not remove the body after death.																	
22b. SIGNATURE										DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED			
Lewis Kelley, MD										MD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11/15/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							22f. DATE SIGNED							
Lewis Kelley, MD			4000 Olney Langtonsville Rd. Olney, Md. 20832														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY	STATE						
Burial			21 NOV 1986		Eden Cemetery			Lansdowne, PA									
24. FUNERAL DIRECTOR NAME			ADDRESS							25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi F.H.			11800 N.H. Ave Sil.Spg. MD							NOV 17 1986				Julia Jackson-Lindell			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32431			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
HARRY CHERKASSKY						11-19-86			2:00	A		M	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			WHITE	MONTH	DAY	YEAR	79			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
NEW YORK			U. S. A.						MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
ROCKVILLE			HEBREW HOME OF GREATER WASHINGTON			VIOLINIST			NATIONAL SYMPHONY				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND			MONTGOMERY	ROCKVILLE						6121 MONTROSE ROAD 20852			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST				
BENJAMIN					CHERKASSKY	ETTIE			LEFF				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ELLEN J. EHRLICH, ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			579-07-1403A			10721 SENECA SPRING WAY GAITHERSBURG, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Failure</u> DOUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple Myeloma</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) <input type="checkbox"/> (his hospital) attended the deceased from <u>7-20-86</u> to <u>11-19-86</u> , that (I) <input type="checkbox"/> (we) <input checked="" type="checkbox"/> saw the deceased alive on <u>11-19-86</u> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <u>Loreto L. Albiol, MD</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11-19-86</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LORETO ALBIOL</u>			22e. ADDRESS <u>6121 MONTROSE Rd.</u>										
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 11/21/1986			23c. LOCATION DISTRICT OF COLUMBIA LODGE CEMETERY			23d. LOCATION CITY OR TOWN WASHINGTON			COUNTY	STATE D. C.
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.			25a. DATE REC'D. BY REGISTRAR NOV 24 1986			25b. REGISTRAR'S SIGNATURE <u>Julia Sander-Padilla</u>							
DHMH - 16 60M 7/84 (VRA 15, 4)													

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

informed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 2 4 3 8

				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)	FIRST <i>IOLA</i>	MIDDLE <i>C.</i>	LAST <i>CHILDS</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>11 20 86</i>	2b. HOUR <i>1030 AM</i>
3. SEX <i>F</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 30, 1899</i>	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Nurse</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Prince Georges</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>9205 New Hampshire Ave. 20903</i>	
14. FATHER'S NAME FIRST <i>Newton</i>	MIDDLE <i>White</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Annie Jane</i> (Unknown)	MIDDLE	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. <i>579-50-9698</i>	17. INFORMANT <i>Freeman Coble, 9205 New Hampshire Ave. Silver</i>	ADDRESS <i>Spring, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive intra cerebral hemorrhage.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Aspiration Pneumonia, Respiratory failure.</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>11/19/86</i> to <i>11/20/86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>A. A. Chacko</i>	DEGREE MP	ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>11/20/86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. A. CHACKO</i>	22e. ADDRESS <i>7610 Carroll Ave # 390 Takoma Park MD 20910</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>11/25/86</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Lincoln Memorial Cem.</i>	23d. LOCATION CITY OR TOWN <i>Suitland Prince Georges, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>NOV 28 1986</i>	25b. REGISTRAR'S SIGNATURE <i>Julia Deidra Rendall</i>
24. FUNERAL DIRECTOR NAME <i>McGuire Funeral Service 7400 Georgia Ave. N.W.</i>	ADDRESS <i>Washington, DC</i>				

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Section 101 - Lecture 10: Interactions - Non-covalent

Non-covalent interactions between molecules

(London, van der Waals)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 86 32439
1. DECEASED NAME (TYPE OR PRINT) Laura B. Cissel			2a. DATE OF DEATH MONTH DAY YEAR November 30, 1986			2b. HOUR 12:54pm
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 26, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3 West Argyle Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Not Available		MIDDLE 		LAST 		15. MOTHER'S MAIDEN NAME FIRST Sarah
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-48-1401		17. INFORMANT R. Humphrey Cissel		ADDRESS Same as # 13.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral anoxia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary disease 8 years 3 days 3 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. arteriosclerosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from March 24, 1955 to Nov. 30, 1986 , that (I) never saw the deceased alive on Nov. 30, 1986 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) never did (did not) view the body after death.						
22b. SIGNATURE Stephen C. Cromwell, M.D.		DEGREE 		22c. DATE SIGNED Dec. 1, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen C. Cromwell, M.D.		22e. ADDRESS 615 West Montgomery Ave. Rockville MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 4, 1986		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		23d. LOCATION CITY OR TOWN Rockville COUNTY Montgomery STATE Maryland
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOME		ADDRESS PA 300 West Montgomery Ave. Rockville, MD		DATE REC'D. BY REGISTRAR DEC 3 1986		25b. REGISTRAR'S SIGNATURE Julia Sinden-Randall

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "None" in Part 1, there is no injury or other traumatic event; the medical certification section need not be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 86 32440						
1. DECEASED NAME Katie E. Clarke	FIRST	MIDDLE	LAST	2a. DATE OF DEATH 11-15-86	MONTH	DAY	YEAR	2b. HOUR 6 AM			
1. SEX Female	4. RACE white	5. DATE OF BIRTH 9 18 88			6. AGE (IN YEARS LAST BIRTHDAY) 98	IF UNDER 1 YEAR YRS	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE Washington DC	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Ct.						
10. CITY OR TOWN OF DEATH Kensington Garden, NH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13818 Shannon Dr.					12a. USUAL OCCUPATION Cashier					
12. STATE MD	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES		13e. STREET ADDRESS / ZIP CODE 13818 Shannon Dr. 20904			12b. KIND OF BUSINESS OR INDUSTRY Business (STORE)			
14. FATHER'S NAME Allen	FIRST	MIDDLE	LAST Clarke	15. MOTHER'S MAIDEN NAME Elizabeth		MIDDLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 578-28-8863		17. INFORMANT Mr Albert B.C. Clarke (son)		ADDRESS 13818 Shannon Dr.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12d. 3				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 1 1960 to 15 Mar 1986 , that (I) () last saw the deceased alive on 11/10/86 at 19 , and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William D. Aud MD											
22c. DEGREE MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Aud MD.											
22e. ADDRESS 9006 Colesville Rd S1. Spg. Md 20910											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 11-17-1986	23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORY			23d. LOCATION CITY OR TOWN RIVERDALE, P.G.C.B. Md.						
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.	ADDRESS 20910 SILVER SPRING, Md.		25a. DATE REC'D. BY REGISTRAR NOV 24 1986			25b. REGISTRAR'S SIGNATURE					
BP_____	DHMH - 16 60M 7/B4 (VRA 15, 4)										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

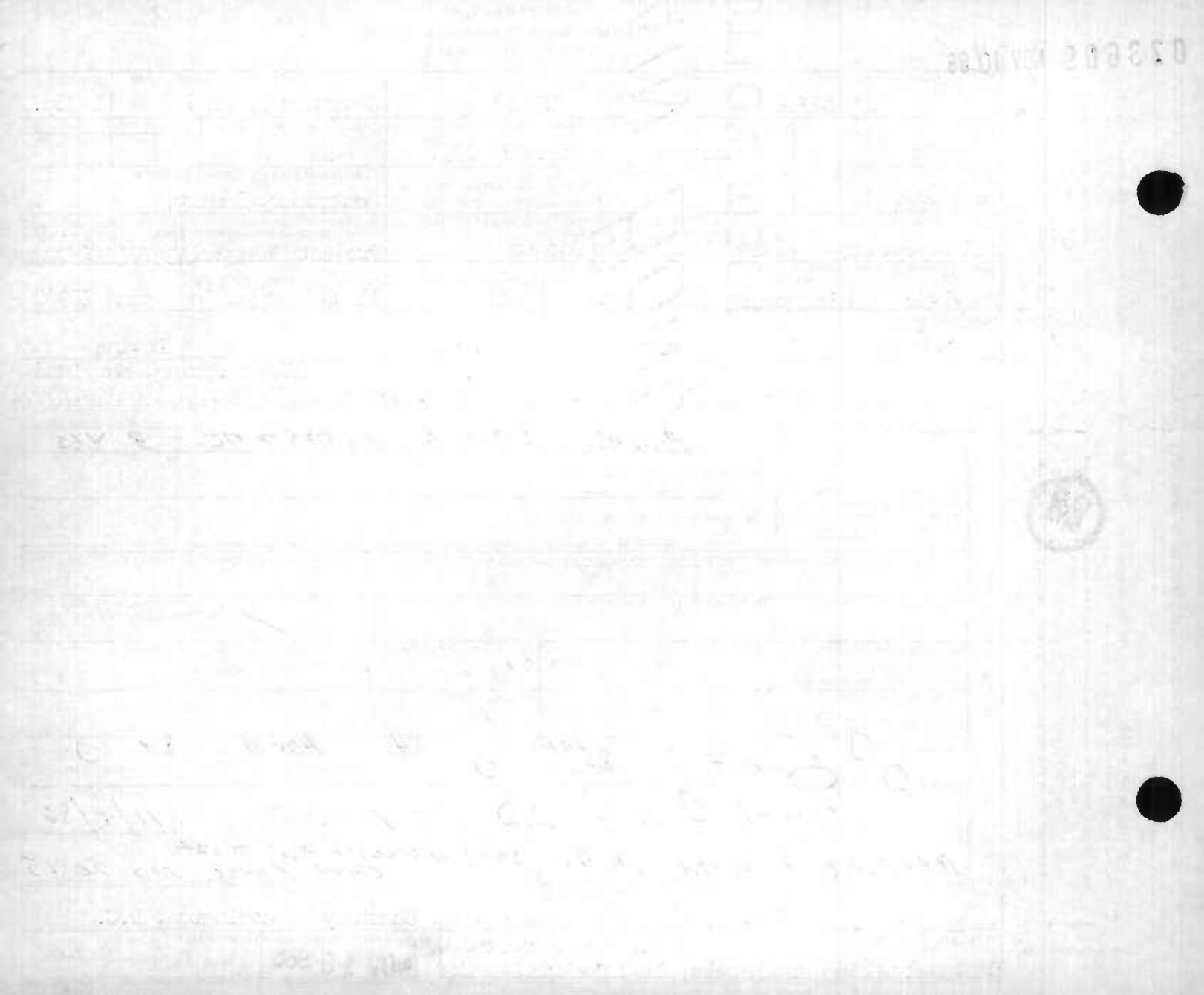
TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial-transit permit. Then it should be filed with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury or

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86324	
										REG. NO.	
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
BARBARA			A.		COHEN		November 5, 1986				3:35 p.m.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)					
Female		Caucasian		Dec. 27, 1934		51		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring		11305 Monticello Avenue								12b. KIND OF BUSINESS OR INDUSTRY Dept. of Educational Activities WETA	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Sil. Spg..		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11305 Monticello Avenue 20902			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE		LAST		
Norman		B.		Abrams	Celia				Levine		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		084-30-7681		Stanley M. Cohen; 11305 Monticello Ave. 20902		Silver Spring, Maryland		3 yrs			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BREAST CANCER, METASTATIC</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 84 to Nov 5 19 86, that (I) (we) last saw the deceased alive on 11/4 19 86, and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Margie A. Voith MD</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/5/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARGIE A. VOITH M.D.</i>		22e. ADDRESS 5530 WISCONSIN AVE #1240 CHEVY CHASE MD 20815									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Nov. 7, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Adas Israel Cong. Cemetery		23d. LOCATION Washington, D.C.		CITY OR TOWN		COUNTY	STATE
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 10 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Leadelle</i>					
DHMH - 16 60M 7/84 (VRA 15, 4)											

2011/03/20 08:50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from this Hospital or Attending Physician's copy. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If Item 21 is marked "Yes" and if any injury, or other traumatic event, the medical

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86 32 442			
FOR STATE REGISTRAR 186				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
SARAH						COHEN		NOVEMBER 17, 1986					9:59 P M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH NOVEMBER		DAY 25, 1905		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	IF UNDER 24 HRS				
7a. BIRTHPLACE COUNTRY RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED XX		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		MONTHS	YEARS	HOURS	MIN.
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6105 MONTROSE ROAD		20852					
14. FATHER'S NAME SAMUEL		15. MOTHER'S MAIDEN NAME GOLDIE													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 161-24-9946B		17. INFORMANT DAVID COHEN, 6111 MONTROSE ROAD, ROCKVILLE, MARYLAND											
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <i>Sepsis</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>IDDM, hyperlipidemia, hypertension, cancer of liver</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-11</i> , 19 <i>83</i> , to <i>11-17</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>11-17</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22c. DATE SIGNED <i>11-18-86</i>			
22b. SIGNATURE <i>Philip Schwartz</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Philip Schwartz</i>		22e. ADDRESS <i>15225 SHADY SPRUCE DR, ROCKVILLE, MD 20850</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/20/1986		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS MOUNT SHARON CEMETERY		23d. LOCATION CITY OR TOWN SPRINGFIELD, DELAWARE PENN.									
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR NOV 24 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson</i>											

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NOV 28 1986
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 2 4 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR			
Christine Elizabeth Cole						11	17	86	11 20 AM				
3. SEX			4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female			Caucasian	MONTH	DAY	YEAR	70		MONTHS	DAYS	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Pennsylvania			United States				Montgomery County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda			Suburban Hospital		Secretary		Engineering						
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 20814 4949 Battery Lane #315/	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Melvin			Luther	French	Caroline			Hamlin	Maurer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (Husband) Carroll G. Cole, #315, Bethesda, MD			ADDRESS 4949 Battery Lane					
No N/A			133-10-6767										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Cardiac Arrest													
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Aortic Stenosis													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>stable melleus, coronary artery disease</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/13, 1986, to 11/17, 1986, that (I) (we) lost sow the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Wilhelmina G. Cain, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED November 17 1986				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilhelmina G. Cain, M.D.			22e. ADDRESS 4912 HORITAN ST. Rockville, Md 20853										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1986	23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Cremation November 18													
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes P.A. 7557 Wisconsin Avenue, Bethesda, MD			25a. DATE REC'D. BY REGISTRAR NOV 24 1986			25b. REGISTRAR'S SIGNATURE <i>John P. Pumphrey</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, place in envelope, seal and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

ANALYSIS

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

DECESSED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

9:30 A

VIRGINIA STEWART COLLINS

M

3 SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

MONTH OCTOBER
DAY 9
YEAR 1895

6. AGE (IN YEARS LAST BIRTHDAY)

91

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS
MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

NEW JERSEY

7b. CITIZEN OF WHAT COUNTRY?

UNITED STATES

8. MARRIED NEVER MARRIED WIDOWED DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10. CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

NAVAL HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY

AT HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

DISTRICT OF COLUMBIA

13b. COUNTY

WASHINGTON

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS / ZIP CODE

6200 OREGON AVENUE, NW 20015

14. FATHER'S NAME

FIRST

MIDDLE

LAST

ULYSSES STEWART

15. MOTHER'S MAIDEN NAME

FIRST

LAST

AGNES BEATTIE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

NO

16b. SOCIAL SECURITY NO.

577-84-4242

17. INFORMANT

JAMES L. COLLINS, JR., P.O.BOX 1331, MIDDLEBURG,

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

VA 22117

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES NO 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

WHILE NOT WHILE
AT WORK AT WORK 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 27, 19 86, to NOVEMBER 3, 19 86, that (I) (we) lost
the deceased alive on NOVEMBER 3, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

MD

ATTENDING PHYSICIAN DIRECTOR STAFF PHYSICIAN

22c. DATE SIGNED

24 Nov 86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

R. M. KEATING, LT, MC, USNR

22e. ADDRESS

NAVAL HOSPITAL

BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

CREMATION

23b. DATE

11-5-1986

23c. NAME OF CEMETERY OR CREMATORI

CHAMBERS CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

RIVERDALE, P.G.C. Md.

24. FUNERAL DIRECTOR

NAME

W. W. CHAMBERS CO. INC.

ADDRESS

20910 SILVER SPRING, Md.

25a. DATE REC'D. BY REGISTRAR

NOV 10 1986

25b. REGISTRAR'S SIGNATURE

Julia Deardon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use on the burial/transit permit. Then place it with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, illness or disease, the medical examiner must be notified at once.

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DMH - 16 60M 7/84
(VRA 15, 4)

023600 10102



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE WORD "PENDING" IN PENCIL IN ITEM 1B. PRINT NAMES ON PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH EDITION PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. RAISES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
John	J.	Connelly Jr.		Nov. 3	1986	8	P.M.	8:00 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. HOURS	10. MIN.	
M	W	July 9 1964	22					
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	12. CITIZEN OF WHAT COUNTRY?	13. MARRIED WIDOWED	14. NEVER MARRIED	15. DIVORCED	16. BALTIMORE CITY OR COUNTY OF DEATH 11. MARYLAND			
Penn.	U.S.A.							
17. CITY OR TOWN OF DEATH	18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Silver Spring	Holy Cross Hosp				Admin.			
20. USUAL RESIDENCE (IF IN THE CITY OR TOWN OF OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	21. STATE COUNTY	22. CITY OR TOWN	23. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	24. STREET ADDRESS	25. KIND OF BUSINESS Agency			
25. Father's NAME FIRST	MIDDLE	LAST	26. Mother's Maiden Name FIRST	MIDDLE	27. LAST	28. 20783		
John	J.	Connelly, Sr.	Ella	J.	Shivers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
yes	W.W. II 169-16-3993	Bernadette H. Connelly wife same as #13						
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>								
20. MEDICAL CERTIFICATION	21a. DATE OF OPERATION <i>None</i>	21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21h. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	22b. TITLE (SPECIFY) M.D.	22c. MEDICAL EXAMINER John S. Rogers, M.D.	22d. DATE SIGNED Nov 4 1986					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial Nov. 7, 86	23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery	23d. LOCATION CITY/TOWN Silver Spring	COUNTY	STATE			
24. FUNERAL DIRECTOR NAME	ADDRESS	Francis J. Collins, Jr.	25a. DATE REC'D. BY REGISTRAR Nov. 8 1986	25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>				
BP _____	DHMH - 17 (VR A15 ME (5))	500 University Blvd. West, Silver Spring, Md.						

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10 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use at the funeral home or mortuary. It should not be carbon copied. If it is necessary to make a carbon copy, it should be done on one side only. In all cases, the original should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked on Item 18 showing injury or other traumatic event, the medical examiner must be notified of once

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32 446	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		LAST Campbell MIDDLE <u>CAMPBELL.</u>			FIRS Cora V.		2d. DATE OF DEATH MONTH DAY YEAR			2d HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH 2 DAY 25 YEAR 23			6. AGE (IN YEARS LAST BIRTHDAY) 63			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u>			MD.	
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Typist</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Federal Govt.</u>				
13a. STATE <u>M.D.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>8242 New Hampshire Avenue 20903</u>	
14. FATHER'S NAME FIRST <u>Harrison</u>		MIDDLE		LAST <u>Campbell</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Catherine</u>			LAST <u>Logan</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>224-28-4662</u>		17. INFORMANT <u>Deborah Roland</u>			ADDRESS <u>1801 Jasmine Terr #102 Adelphi, MD 20783</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiopulmonary</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Tobacco abuse</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFIED MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1989</u> 19 to <u>11-18-86</u> 19, that (I/we) last saw the deceased alive on <u>11-18-86</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.											
22b. DATE SIGNED <u>1-18-86</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles L Franklin Jr</u>		22e. ADDRESS <u>11120 New Hampshire Ave Silver Spring Md 20904</u>			22f. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/22/86</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Harmony Memorial Park</u>			23d. LOCATION CITY OR TOWN <u>Landover Prince George's MD</u>		COUNTY		STATE
24. FUNERAL DIRECTOR NAME <u>Rollins Funeral Home, Inc.</u> <u>4339 Hunt Place N.E., Washington, D.C. 20019</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 24 1986</u>			25b. REGISTRAR'S SIGNATURE <u>Julia [Signature]</u>						

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit carbon copy of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	32441		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
James B. Craig			JAMES	B.	CRAIG	11-15-86						4:15 AM	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
<input checked="" type="checkbox"/> Male			White		Sept. 30, 1912 ^{AR}			74			MONTHS	DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor-Writer Amer. Forestry Assn.			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7410 Arden Rd. 20818				
14. FATHER'S NAME FIRST George			MIDDLE LAST Craig		15. MOTHER'S MAIDEN NAME FIRST Gertrude			16. ADDRESS Barkley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Marjorie R. Craig Same as item # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			from negative Sepsis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Prostate						1 year				
(c)			DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Central metastasis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from Sept. 85, 19 to Nov. 15, 19, that (I) (we) last saw the deceased alive on 11-15-86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									COUNTY				
22b. SIGNATURE Jeremy V. Cooke			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			STATE				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke			22e. ADDRESS 10400 Conn. Ave., Kensington Md			22f. DATE SIGNED 11/16/86							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 11/17/86			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Comfort Crematory			23d. LOCATION CITY OR TOWN Alexandria, VA				
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016						25a. DATE REC'D. BY REGISTRAR NOV 20 1986			25b. REGISTRAR'S SIGNATURE Julia Jackson-Lundquist				

2011-01-22



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the funeral director. Page 3 should be detached for use as the burial permit. Then please remove or photocopy Pages 1 and 2 and attach to the burial permit.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove or photocopy Pages 1 and 2 and attach to the burial permit.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 80 32 34 41 8				
1. DECEASED NAME (TYPE OR PRINT)			FIRST KEITH	MIDDLE EUGENE	LAST CRAWFORD	2a. DATE OF DEATH OCT 22 1986	2b. HOUR M			
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DEC DAY 05 YEAR 1986		6. AGE (IN YEARS LAST BIRTHDAY) 39 years YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH None Mont. MD.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Chesapeake Bay Naval Hosp.			12a. USUAL OCCUPATION PILOT		12b. KIND OF BUSINESS OR INDUSTRY US NAVY		
13a. STATE VIRGINIA			13b. COUNTY Fairfax Co		13c. CITY OR TOWN SPRINGFIELD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7800 ODELL ST 22153	
14. FATHER'S NAME FRANK EDWARD CRAWFORD			15. MOTHER'S MAIDEN NAME EVELYN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ACTIVE DUTY 281-44-4127		17. INFORMANT MARY CRAWFORD		ADDRESS 7800 ODELL ST, SPRINGFIELD, VA				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AIRCRAFT ACCIDENT 8419 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. OCT 22 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) AIRCRAFT MISHAP						
21d. INJURY OCCURRED NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) CHESAPEAKE BAY		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Mont. Md.						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Alan W. Cashell</i>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN W. CASHELL		22e. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22f. DATE SIGNED 10 NOV 1986				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 14/86		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, Virginia				
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO., INC. SILVER SPRING, MARYLAND		25a. DATE REC'D. BY REGISTRAR NOV 20 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Kendall</i>						

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Wiederholung der Arbeit

Wiederholung der Arbeit

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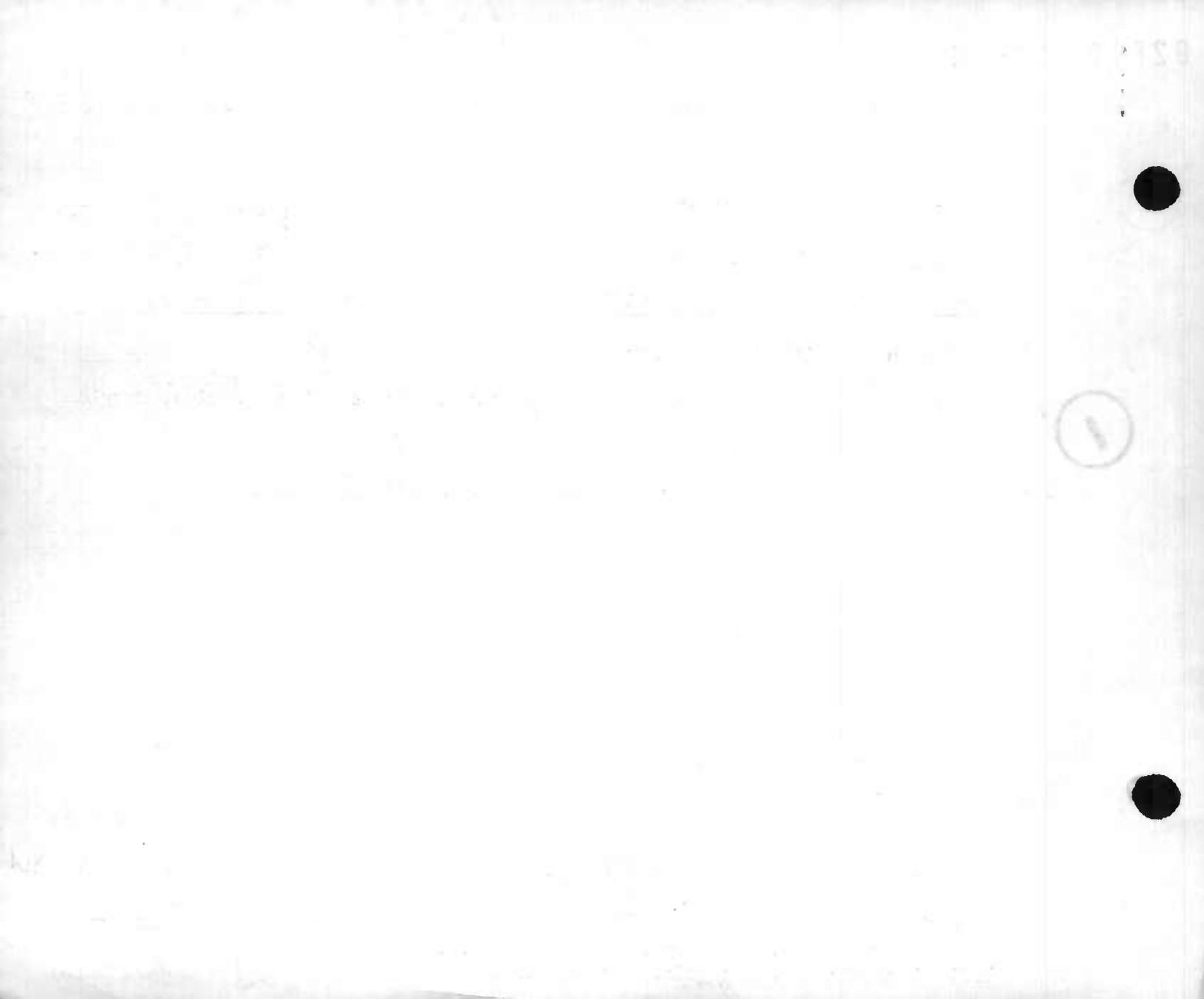
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. The medical examiner must be notified of once.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 86 32449
1. DECEASED NAME (TYPE OR PRINT) Emma Geneva Cronise			2a. DATE OF DEATH MONTH DAY YEAR 11 - 28 - 86			2b. HOUR 12.31 PM
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8-22-95		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Fuel Oil Co.
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY, OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Joseph		MIDDLE Millard		LAST Peake		15. MOTHER'S MAIDEN NAME FIRST Emma
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-01-0789		17. INFORMANT Sharon M. Strout		18. ADDRESS 12610 Epping Road Silver Spring, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to, or as a consequence of (b) cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Due to, or as a consequence of (c) atherosclerotic heart disease.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-13 19 86 , to 11-28 19 86 , that (I) (we) last saw the deceased alive on 11-13 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Donald L Bucy		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-28-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L Bucy / SN Jones		22e. ADDRESS 809 Veirs Mill Rd Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 2, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park		23d. LOCATION CITY OR TOWN Rockville
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.		25a. ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland 20814		25b. DATE REC'D. BY REGISTRAR DEC 2 1986		25b. REGISTRAR'S SIGNATURE Julia Wilson-Lindner



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/cremation permit. Then please remove carbon copy of this certificate and attach it to the burial/cremation permit. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 32 50			
										REG. NO.			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
DECEDENT'S NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		11 07 86			5:55 PM			
PAUL EDWARD CROSBY													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE		CAUCASIAN		04 20 1919			67 YRS			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY			IF UNDER 24 HRS			
OHIO		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		NAVAL HOSPITAL BETHESDA							FIREFIGHTER				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE			
13a. STATE MARYLAND		13b. COUNTY ST MARY'S		13c. CITY OR TOWN ST INIGOES			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			STAR ROUTE BOX 60N 20684			
14. FATHER'S NAME BURT NMN CROSBY		15. MOTHER'S MAIDEN NAME NORA NMN ELLIOT											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1936-1959		16c. INFORMANT NATHALIA CROSBY WIFE		16d. ADDRESS STAR ROUTE BOX 60N 20684		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										BRAIN DEATH; ABSENT CEREBRAL BLOODFLOW			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF CEREBRAL ANEURYSM			
(b)													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from October 31, 1986, to November 7, 1986, that (I) (we) last saw the deceased alive on NOVEMBER 3, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED NOV 86			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>							22d. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814				
W.S. FISHER LCDR MC, USN													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/12/86		23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S			23d. LOCATION CITY OR TOWN RIDGE, ST. MARY'S, MARYLAND		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		25a. DATE REC'D. BY REGISTRAR NOV 13 1986							25b. REGISTRAR'S SIGNATURE Lorraine Radford				
DHMH - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

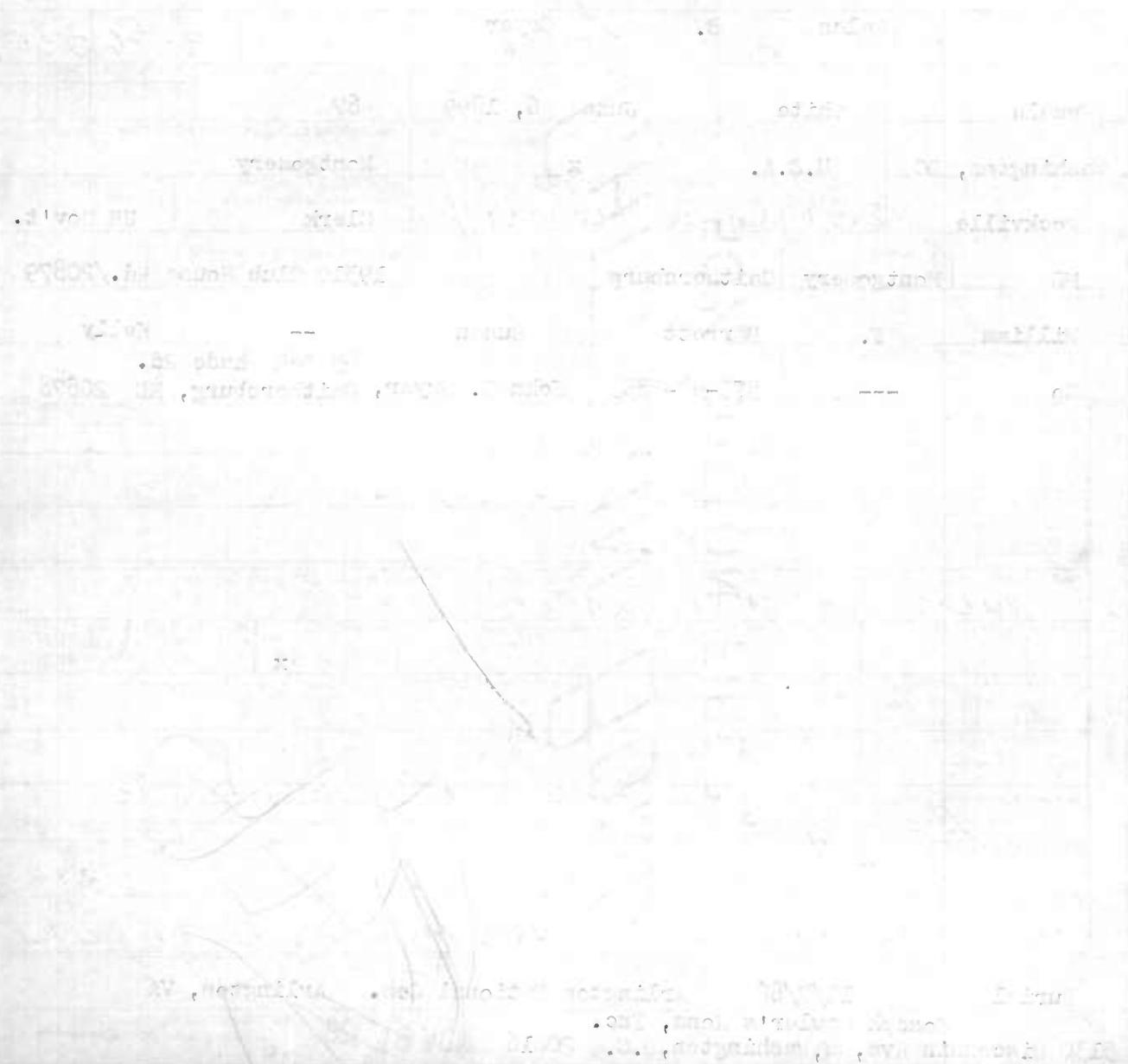
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 6 3 2 4 5

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Helen</i>	MIDDLE <i>B.</i>	LAST <i>Cryer</i>	2a DATE OF DEATH MONTH YEAR	MONTH	DAY	YEAR	2b. HOUR			
							<i>JUNE 6, 1899</i>	<i>JUNE</i>	<i>6</i>	<i>1899</i>	<i>11-3-86 2357</i>			
3. SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 87			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY US Gov't.							
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 19310 Club House Rd./20879				
14. FATHER'S NAME FIRST William		MIDDLE F.		LAST Barrett			15. MOTHER'S MAIDEN NAME FIRST Susan			MIDDLE —			LAST Kelly	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-48-2355		17. INFORMANT ADDRESS John B. Cryer, Gaithersburg, MD 20878										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>BILATERAL PNEUMONIA</i>												
		(c) <i>ASPIRATION</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>PULMONARY TUBERCULOSIS</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>June 19, 86</i> to <i>Nov 4, 86</i> , that (I) (we) last saw the deceased alive on <i>Nov. 3, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Mario O. Belledonne</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>11/3/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIO O. BELLEDONNE		22e. ADDRESS 14816 PHYSICIANS LN 251 ROCKVILLE												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/7/86		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.			23d. LOCATION CITY OR TOWN Arlington, VA			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C.		25a. DATE REC'D. BY REGISTRAR NOV 6 1986			25b. REGISTRAR'S SIGNATURE <i>Julie Gender-Kendall</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified of all such injuries.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 3 2 4 5 2						
										REG. NO.						
1 - STATE REGISTRAR		2d. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		RAYE		B.				CRYSTAL		11/08/86				1986	5 1/2 AM	
1. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.				
Female		Caucasian		Feb. 18, 1903				83 YRS		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		USA						Montgomery						MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY								
Rockville		Hebrew Home of Greater Wash.		Housewife												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE								
Maryland		Montg.		Sil. Spg.				8107 Eastern Ave. 20910								
14. FATHER'S NAME FIRST		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST								
unknown				unknown												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. DEATH PLACE		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
NO		YS 579-24-6916		Bert Crystal; 2614 Kennison Lane		Bowie, Maryland 20715		3 MONTHS								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										ACUTE RESPIRATORY FAILURE						
Conditions, if any, which gave rise to immediate cause 18a, stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CANCER OF LUNG						
(c)										DUE TO, OR AS A CONSEQUENCE OF						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3/26/86 to 11/8/86, that (I) (we) last saw the deceased alive on 11/8/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>M. Patel</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 11/8/86										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) D.J. PATEL		22f. ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE 11-9-1986		23c. NAME OF CEMETERY OR CREMATORIAL King David Mem. Gdn. Falls Church, Va.		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE						
Burial				Rockville, Maryland												
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Mem. Chapels		ADDRESS 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR NOV 14 1986		25b. REGISTRAR'S SIGNATURE <i>K. Danzansky</i>										
BP																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this form. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Thelma W. Cummings						Nov. 24, 1986		4:58 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Month Day Year Feb. 5, 1906		80		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10225 Kensington Parkway/20895					
14. FATHER'S NAME FIRST Charles		MIDDLE K.		LAST Walker		15. MOTHER'S MAIDEN NAME FIRST Laura		MIDDLE R.		LAST Lusky			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-54-7607		17. INFORMANT Patricia C. Solomon, Silver Spring, MD		ADMITTED 11/24/86		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PANCREAS													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 80</u> , 19 <u>80</u> , to <u>11/24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Richard H. Pollen</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/26/86							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Pollen		22f. ADDRESS 10400 Conn. Ave., Kensington, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-28-86		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR DEC 1 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be attached to the burial permit. Then phone the State Dept. of Health and Mental Hygiene prior to burial concerning any important item.

IMPORTANT: If item 21 is marked on Item 18 shows any injury or other findings under the medical certification, the medical record number 18 should be attached to the funeral director, page 3.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	32454														
										REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR													
Louise Reilly Davis			Louise	REILLY	DAVIS	NOVEMBER 21, 1986			NOVEMBER	21	1986	10:15 P													
3. SEX			4. RACE			DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH								
Female			White			Month Sept. Day 12, Year 1891			IF UNDER 1 YEAR MONTHS DAYS			MD		U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			EMK Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. STATE		13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Chevy Chase			4001 Rosemary St.			Homemaker			Home			MD		Mont.			Chevy Chase			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4001 Rosemary St.		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Louis			W.	Reilly	Rose	C. Mapes			No	Lillian R. Kessel Same as item # 13			No		220-46-4806						3 MONTHS				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR -			DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										CHRONIC RENAL FAILURE															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE										
22a. I certify that (I) (the hospital) attended the deceased from NOVEMBER 7, 1986, to NOVEMBER 21, 1986, that (I) (we) lost saw the deceased alive on NOVEMBER 21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Edward W. Youngblood, M.D.										22c. DATE SIGNED 11/01/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.			23d. LOCATION CITY OR TOWN Baltimore, MD			COUNTY			STATE										
Edward W. Youngblood, M.D.						4900 MA Ave. NW Wash., DC 20016																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/25/86			23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.			23d. LOCATION CITY OR TOWN Baltimore, MD			COUNTY			STATE										
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016						25a. DATE REC'D. BY REGISTRAR NOV 2 8 1986			25b. REGISTRAR'S SIGNATURE Asia Deidra Readell																

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city visit sheet

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110 HOSPITAL OR ATTENDING PHYSICIAN

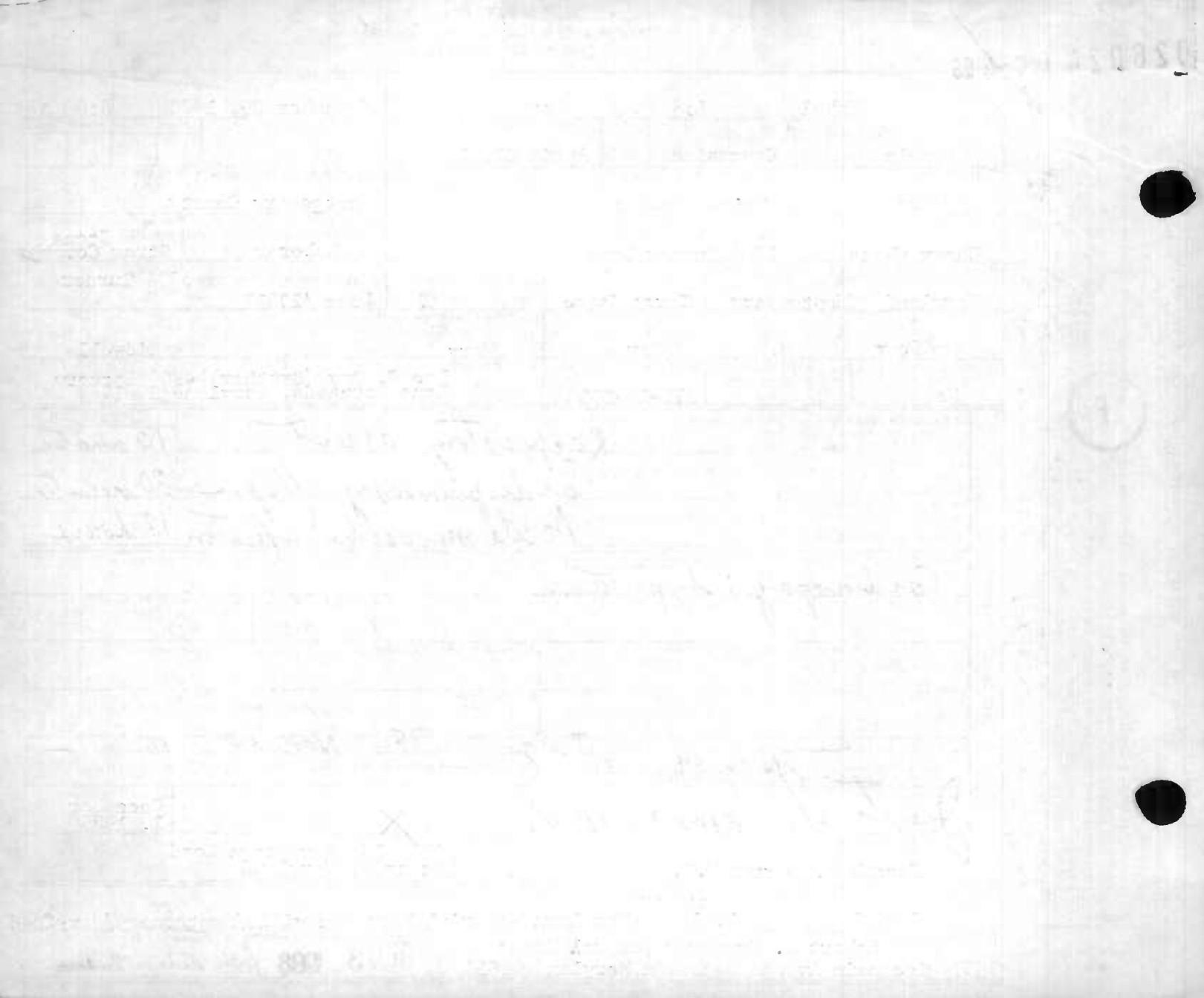
case in executed within 24 hours after death. Page 4 may be

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

DECEDENT'S NAME (TYPE OR PRINT)			FIRST Mabel	MIDDLE Lee	LAST Day	DATE OF DEATH MONTH DAY YEAR	YEAR	2b. HOUR 6:00 a.m.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 22, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3504 Turner Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Stone Straw Company			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Lane / 20815	
14. FATHER'S NAME FIRST Godfrey		MIDDLE M.		LAST Day		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE LAST Kidwell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-10-2520		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction		17. INFORMANT Leo C. Day (Brother)		ADDRESS 4900 Battery Lane Bethesda, Maryland 20814	
								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 30 minutes 12 hours	
PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Cardiogangli hypertonia									
18. DATE OF OPERATION		19. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) the hospital attended the deceased from July 19, 1978, to Nov. 30, 1986, that (I) saw the deceased alive on Nov. 29, 1986, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.									
22b. SIGNATURE Joseph D. Connor, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph D. Connor M.D.		22e. ADDRESS 9420 Old Georgetown Road Bethesda, Maryland		22d. DATE SIGNED December 1, 1986					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE December 3, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park		23d. LOCATION Rockville/Montgomery/Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA 7557 Wisconsin Avenue Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR DEC 3 1986		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
<i>Mae H. Decatur</i>						11	9	86		4 PM M
3. SEX	4. RACE	5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<input checked="" type="checkbox"/> F Female	White	7-31-1908	MONTH	DAY	YEAR	78 YRS.	MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA						<i>Prince George MD</i>			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park	Washington Adventist Hospital			Beautician			Hairstressin			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE			13f APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Maryland	Pr George	Upper Marlboro	NO <input type="checkbox"/>			Melwood Road			20772	
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST		
			King	Fannie						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			
No	579-18-6509			Dora King			Maryland 109 Dickens St Glen Burnie			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Reactory failure</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterial disease</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic bron</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Obesity</i>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)						
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/>										
22a. I certify that I (We) attended the deceased from <i>10/11/86</i> , 19 <i>86</i> , to <i>10/11/86</i> , 19 <i>86</i> , that <input checked="" type="checkbox"/> (we) lost say, the deceased above on <i>10/11/86</i> , 19 <i>86</i> , and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/We) did not view the body after death.										
22b. SIGNATURE <i>Lewis H Dennis, M.D.</i> DEGREE										
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <i>11/10/86</i>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
Lewis H Dennis, M.D.			831 University Blvd EAst Silver Sp., Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY	23f. STATE		
Burial	12Nov1986	Mt Olivet Cemetery			Frederick		Frdck	Md		
24. FUNERAL HOME NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert E Wilhelm Funeral Home	Suitland, Md			Nov 18 1986			<i>Robert E. Wilhelm</i>			

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